OIG RELEASES WHITE PAPER ON EVIDENCE SUPPORTING ADMINISTRATIVE CLOSURE OF 2014 TOMAH, WI, VA MEDICAL CENTER INSPECTION ON OPIOID PRESCRIPTION PRACTICE

"Facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passion, they cannot alter the state of facts and evidence." John Adams

Since February 2015, the Office of Inspector General (OIG) has been working in good faith to provide the Senate Homeland Security and Governmental Affairs Committee with evidence supporting the OIG's decision to administratively close the healthcare inspection into allegations of inappropriate opioid prescription practices at the Tomah, Wisconsin, VA Medical Center (VAMC), while balancing our obligation to protect sensitive information in veterans' medical records, VA quality assurance documents, and the names of complainants and witnesses promised confidentiality by our inspectors. Nonetheless, on April 29, 2015, the Committee issued a subpoena seeking records that was significantly broader than the records initially requested in February 2015, and for some records that we previously provided to the Committee, including 140 healthcare administrative closures issued from 2006 to 2015.

In less than 4 weeks from receipt of the Committee's subpoena, the OIG produced 13,949 pages of documents, withholding 1,812 pages of medical records to protect the identity of patients and their sensitive health information and other documents that represented the internal OIG deliberative process. Because no Committee Members had requested a briefing on our Tomah inspection, on June 4, 2015, we provided each Committee Member with a white paper with an analysis of the evidence to support our decision to administratively close the inspection. The white paper was also provided to the Senate Majority and Minority Leaders, the House Veterans' Affairs Committee Chairman, the Senate Veterans' Affairs Committee Chairman, and other interested Members that addresses the following key points:

- Who knew what and when.
- Lack of supporting evidence of early refills and opioids being prescribed to treat Post Traumatic Stress Disorder.
- Lack of supporting evidence that drugs were being diverted.
- Misunderstanding that the administrative closure addressed tragedies or veterans' deaths.
- Retaliation for whistleblowing.
- Culture of fear at the Tomah facility.

Our white paper lays out the facts and evidence—separating them from unsupported opinions and rumors circulating about the Tomah facility and our inspection—and cites the underlying documents and transcripts of interviews collected during an exhaustive 2-year inspection that OIG expert psychiatrists, physicians, and health care staff relied on in reaching the conclusion that the majority of allegations relating to prescribing practices and related issues were not substantiated.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

June 4, 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and
Governmental Affairs
United States Senate
Washington, DC 20510-6250

Dear Mr. Chairman:

This letter summarizes the response by the Department of Veterans Affairs Office of Inspector General to the subpoena that you issued on the evening of April 29, 2015. The subpoena sought records pertaining to our healthcare inspection of the VA medical center in Tomah, Wisconsin, which took place from August 2011 through 2012. Your subpoena was significantly broader than the records requested by your staff after a February 2015 briefing and in your subsequent correspondence. For example, the subpoena included 140 administrative closures which your staff knew had already been published on our website. Although your deadline for a response to the subpoena was less than 2 weeks, we produced 13,949 pages of documents in less than 4 weeks, all of which had to be reviewed and appropriately redacted by my legal staff.

With regard to the documents produced, my staff has reviewed all of the records and redacted them as necessary consistent with the legal concerns and restrictions raised in my February 27, 2015, letter. More specifically, we redacted from the transcripts and notes of interviews the names and other identifying information of all current or former employees who were promised and/or requested confidentiality during the inspection. As you can see from various transcripts, many of these individuals were uncomfortable providing information if we were going to release their identity. Unnecessarily releasing the identities of these individuals who expected that their statements would remain confidential would have a chilling effect on our future ability to obtain information from VA employees and other persons with relevant information and would have a significant negative impact on our statutory mission.

We also redacted or withheld information protected from disclosure by Title 38 U.S.C. Section 5701 (patient medical records), 5705 (medical quality assurance records), and 7332 (records relating to the diagnosis and treatment of drug and alcohol abuse, HIV, and sickle cell anemia). The authority to release these records is vested in the VA Secretary, not the Office of Inspector General.

We withheld in their entirety 1,812 pages of medical records pertaining to 7 specific patients. Based on our review of the records, we determined that they could not be redacted in such a manner as to protect the identity of the patients and still provide useful information. These records include very sensitive personal information that the patients disclosed in confidence to the providers. These patients have very complex medical and mental health issues, including suicide attempts, requiring intense treatment plans. To describe these patients as fragile would be a significant understatement. We are concerned about the mental and emotional stability of these patients if they learn that their personal, confidential medical information was disclosed to multiple people outside VA and for non-medical purposes. Based on the VA confidentiality statutes and the Privacy Act, we may have to notify the individuals if we release their medical records, which could be harmful for the reasons stated above. Frankly, neither I nor my staff want to be responsible for the dire consequences that are likely to occur by releasing the medical records to you, your staff, and the other Members of the Committee and their staff. Our decision relating to the medical records is consistent with the statement in your March 15, 2015, letter that "As I have communicated to you and as Committee staff has communicated to your staff, the Committee is not seeking information that would reveal patient specific medical records."

As my legal staff communicated to your staff in an email, we also withheld documents that clearly represented the deliberative process. This included drafts of the administrative closure and communications between VA OIG staff.

Recognizing the voluminous number of documents, the attached white paper highlights evidence obtained and reviewed during the inspection that responds to the focus of your investigation as you have stated in your letters. I caution that we provided all documents relating to our analyses of the data, including information that had not been verified. As such some of the data, such as certain spreadsheets, represents raw data that had not undergone final validation and thus was not relied on in reaching our conclusions.

To ensure transparency in this matter, I am providing this letter, and the attachments, which include the white paper, the administrative closure report, and copies of our prior correspondence to all Committee Members, Members of the Senate Committee on Veterans' Affairs, the Senate Majority and Minority Leaders, and other Members who attended the joint Tomah field hearing on March 30, 2015, so they will have a better understanding of the issues and the evidence that our expert psychiatrists, physicians, and other health care personnel relied on in reaching the findings and conclusions in the administrative closure report.

Sincerely,

RICHARD J. GRIFFIN
Deputy Inspector General

Enclosures

Copy to:

The Honorable Mitch McConnell, Senate Majority Leader
The Honorable Harry Reid, Senate Minority Leader
The Honorable Tom Carper, Ranking Member, Senate Committee on Homeland Security and Governmental Affairs
Members, Senate Committee on Homeland Security and Governmental Affairs
Members, Senate Committee on Veterans' Affairs
The Honorable Jeff Miller, Chairman, House Committee on Veterans' Affairs
The Honorable Corrine Brown, Ranking Member, House Committee on Veterans' Affairs
The Honorable Ralph Abraham, MD
The Honorable Sean Duffy
The Honorable Ron Kind
The Honorable Mark Pocan
The Honorable Tim Walz

WHITE PAPER

ANALYSIS OF THE EVIDENCE SUPPORTING THE FINDINGS OF THE VA OFFICE OF INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS ADMINISTRATIVE CLOSURE OF ITS INSPECTION OF COMPLAINTS REGARDING THE TOMAH, WISCONSIN, VA MEDICAL CENTER

On April 29, 2015, Senator Ron Johnson, in his capacity as Chairman of the Senate Committee for Homeland Security and Governmental Affairs, issued a subpoena to the Department of Veterans Affairs Office of Inspector General (VA OIG) seeking documents relating to a healthcare inspection conducted in or around 2012 at the VA medical center in Tomah, Wisconsin. The inspection, which was administratively closed in March 2014, did not substantiate the majority of the allegations relating to prescribing practices and other related issues. The administrative closure received significant media attention beginning in early January 2015, due to new allegations received in or around September 2014 from a former Tomah VA medical center employee. The inspection was conducted by staff in the VA OIG's Office of Healthcare Inspections and included two physicians board certified in psychiatry, two physicians board certified in internal medicine, a physician board certified by the American Board of Physical Medicine and Rehabilitation, a pharmacist, and other health care personnel. In addition, a Special Agent in our Office of Investigations participated in the interviews and followed up on specific allegations with potential criminal implications. The psychiatrist who led the inspection, Dr. Alan Mallinger, had more than 30 years of experience in the clinical practice of psychiatry before joining the VA OIG Office of Healthcare Inspections. In 2013, he was inducted into the American College of Psychiatrists, which comprises more than 800 psychiatrists who have demonstrated excellence in the field of psychiatry, and achieved national recognition in clinical practice, research, academic leadership, or teaching. The inspection included recorded interviews, review of medical records and other related records, review of background materials, treatment guidelines, medical research, and analyses of data relating to early prescription refills and prescribing practices.

Although Senator Johnson and his staff have publicly criticized our findings, neither he nor any other Member of this Committee has requested to be personally briefed regarding the allegations, our inspection, our findings, and supporting evidence. In fact, Representative Ron Kind is the only Member of Congress who requested and received a personal briefing to discuss the evidence supporting our findings. In response to the subpoena, my staff produced 13,949 pages of documents to both the majority and minority staff. Below I am providing a summary of the evidence as it relates to what Senator Johnson has articulated to be the scope of his investigation in this matter. My staff will be happy to provide a briefing to any Member who wishes to further discuss these issues.

Who knew what and when

During the March 26, 2015, hearing held by the Senate Veterans' Affairs Committee, *Opioid Prescription Policy, Practice, and Procedures*, Senator Johnson stated that he was conducting an investigation to inquire how far back these problems went and who knew so that these "tragedies" do not happen again. He further stated that he wanted to know who knew what and when to hold people accountable. As I explained in my April 24, 2015, letter to Senator Johnson because we did not substantiate the Hotline allegations, it was not necessary for the inspectors to determine who knew what and when for the purpose of holding people accountable. I previously produced copies of records responsive to the scope of the investigation that Senator Johnson` articulated at the hearing with my April 24, 2015, letter. Attached are copies of Senator Johnson's April 20, 2015, letter and my April 24, 2015, response. If any Member of the Committee would like a copy of the documents produced with my response, I will provide them directly to you or your staff.

As I noted in prior correspondence to Senator Johnson, the healthcare inspection was initiated based on an anonymous complaint received by the VA OIG Hotline in August 2011. The complaint we received indicated that the complainant had sent copies to "all of Wisconsin's senators and representatives in Congress." Records produced, pp. 5716-5720. The records produced in response to the subpoena also include statements by an individual who told us during a subsequent interview that she had sent the August 2011 letter. During the interview, the individual reaffirmed that the letter had been sent to all Wisconsin Senators and Representatives. Records produced, p. 5323. Wisconsin Representative Ron Kind forwarded a copy of the letter to the VA OIG Hotline in September 2011. Records produced, pp. 4159-4161. We did not receive this complaint from nor were there any inquiries about any issue regarding the Tomah VA medical center from any other Member of Congress prior to Senator Tammy Baldwin's request in June 2014 after she received a separate complaint. Despite the media attention given the administrative closure, which led to the subpoena, as noted above, Representative Kind is the only Member of Congress who requested and was personally briefed regarding the evidence supporting the conclusions in our administrative closure. My staff and I welcome the opportunity to provide the same detailed briefing to any Member of the Committee or Congress who has an interest in hearing the facts in this matter and answer any questions you may have. Interviews and other information gathered during the inspection related primarily to the 2011-2012 time period. Subsequent to our onsite inspection, which was concluded in late 2012, through the date the inspection was closed administratively in March 2014, we did not receive any similar complaints from Members of Congress, through our Hotline, or from any other source.

VA OIG records show that the first complaint we received regarding problems relating to prescribing practices at the Tomah VAMC was in March 2011. Records produced, pp.1377-1388. The March 2011 complaint was referred to the Veterans Health Administration (VHA) for review and response, and the response was reviewed by the VA OIG, Office of Healthcare

Inspections. The review conducted by VHA substantiated allegations relating to prescribing practices for two of the patients identified in the complaint. VHA provided an action plan that included a review by the Veterans Integrated Systems Network 12 (VISN 12) of refill/lab testing policies, evaluating practice trends, and working with the Chief of Staff at Tomah to evaluate pain approaches and effectiveness. Allegations of travel benefit fraud, poor communications with a patient, and diversion/sale of controlled substances were not substantiated. Records produced, pp. 1389-1391, 1438-1443 (VHA's response). When the VA OIG Hotline received a second complaint in August 2011, Records produced, p. 1388, the VA OIG Office of Healthcare Inspections began its in-depth inspection of the allegations as evidenced by the administrative closure report and the almost 14,000 pages of documents produced in response to the subpoena.

During the inspection and around the same time that we were conducting our onsite work in 2012, another team in the Office of Healthcare Inspections was conducting a cyclical Combined Assessment Program (CAP) review of the Tomah VA medical center. Part of each CAP review includes an Employee Assessment Review (EAR) survey. The employee responses to the 2012 EAR survey included complaints that opioids were being overprescribed. Records produced, pp. 4153-4155. This was the only time that the employee responses to the EAR survey included complaints about prescribing practices at Tomah. In comparison, responses to the EAR survey conducted between August 18 and September 8, 2014, did not include such complaints.

It took us considerable time to conduct the interviews, research the medical issues, review medical and other records, and conduct detailed analyses of large amounts of data to reach conclusions in the administrative closure. To date, no one has presented any evidence to show that our findings and conclusions relating to the prescribing practices and other conditions existing in 2011 and 2012 were in error. Witnesses who testified at the field hearing held by Senator Johnson on March 30, 2015, at the Tomah VA medical center did not include anyone with personal knowledge of the facts and circumstances as they existed during our inspection. One witness, Noelle Johnson, stated in her written statement for the March 30, 2015, field hearing that she had been terminated from her positon at the Tomah VA medical center in June 2009. The other witness, Ryan Honl, was employed at the facility from August 10 to October 2014, when he resigned. He also admitted in his written statement for the May 30, 2015, field hearing that he "wasn't a witness to the over prescription of narcotics. . ." and that his information came from other (unidentified) employees. Similarly, testimony from the family of Thomas Baer was limited to what occurred on January 12, 2015. Mr. Baer had not been seen or treated at the Tomah VA medical center for over 30 years. Similarly, testimony of the family of Jason Simcakowski was limited to their knowledge of his care, not the care of veterans in general at the Tomah VA medical center.

Extensive medical and pharmacy record reviews did not support allegations relating to early refills and opioids being prescribed to treat Post Traumatic Stress Disorder (PTSD)

As noted in our administrative closure, to address these issues we conducted extensive and in-depth reviews of patient records and other information. The review included general chart reviews of the patients who were specifically identified by multiple sources including various individuals who were interviewed during our inspection, patients who were included in a 2011 peer review of Dr. Houlihan's practice, a patient who was identified by an informant to Tomah municipal police as allegedly being involved in drug diversion, and selected individuals from a list of the 100 patients at the Tomah medical center who were receiving the highest doses of opioids. In addition, we performed structured chart reviews and compiled the results of 56 patients, which included all patients (32) in the care of Dr. Houlihan and a nurse practitioner who were among the 100 patients at Tomah having the highest doses of opioids. The 56 patients also included patients on a list provided by the Tomah municipal police department of individuals suspected of drug crimes, who were receiving prescriptions for controlled substances from any provider at Tomah (24 patients). Of the 24 patients, 15 were patients of Dr. Houlihan or the nurse practitioner. Records produced, pp. 4201-4465. We also compiled, reviewed, and analyzed extensive datasets derived from pharmacy records including records relating to early refills of controlled substances and antidepressants (for comparison) over the period of January 1, 2011, to September 12, 2012, (Records produced, pp. 1551-1942), and total morphine equivalents of opioids dispensed during fiscal year (FY) 2012 in all VISN 12 facilities by patient and provider. Records produced, pp. 1946-2057, 2879-4129. We also reviewed and analyzed datasets for early refills for all VISN 12 facilities. Records produced, pp. 2059-2878. The prescription records included more than 150,000 line entries.

As stated in the administrative closure report (p. 9), we did not substantiate the allegation that "opioids are contraindicated for PTSD, but this is part of [Dr. Houlihan's] treatment plan." Based on our review of patient records, we found that none of the patients were prescribed opioids to treat PTSD and a majority of the patients did not have a diagnosis of PTSD listed in the medical record. Records produced, pp. 4202-4282 & 4351-4465. If one accepted the statement that "opioids are contraindicated for PTSD" then patients receiving them even for a co-existing conditions such as pain would be a problem. In fact, however, opioids are not contraindicated in PTSD. *See e.g.*, pp. 13731-13772. Also as stated in the administrative closure report (p. 9), the medical record reviews indicated a history of a pain-related condition(s) and use of opioids for the treatment of pain.

The structured chart review showed that 48 of the 56 patients (86 percent) had entered into narcotics contracts and that 52 of the patients (93 percent) had submitted to urine drug screening (UDS). We noted in the administrative closure report (p. 6), that our medical record review identified four patients who had no UDS performed during the 3-year time interval, although they were treated chronically with opioids during this period. We also stated in the administrative closure that of the 52 patients we identified through the chart reviews who had

UDS performed at least one time between January 2009 and April 2012, we identified 5 patients who were being prescribed opioids at the time of the negative test, i.e., the test failed to confirm that they were actually taking their prescribed medication. *Id.*

With regard to early refills (greater than 7 days early), our extensive reviews of prescription records (cited above) showed that 29 of the 56 patients (56 percent) had early refill(s) of opiates and/or stimulants during a 1 year time interval beginning 366 days before the date that the chart was reviewed (between April 16 and June 14, 2012). For the 29 patients with early refills, the number of early refills per patient ranged from one to eight. Twelve patients had a single refill, and 17 obtained multiple (two or more) early refills during the year. Eight patients obtained early refills on four or more occasions during the year. Records produced, pp. 1151-2041, 5927, 13659-13670. From a clinical perspective, sudden cessation of opiate medication for patients chronically taking opiates is likely to precipitate a withdrawal syndrome involving physical and psychological sequellae. Therefore the undesirability of early refills and potential for drug misuse or diversion needs to be balanced against potential risks and harm associated with opiate withdrawal.

Our various analyses of prescription data from the Tomah and other VA medical centers and among various providers also failed to support many of the allegations. Examples of these analyses can be found at pp. 1551-4152, 12979-13551 of the records produced. We found the early refill rate for January 1, 2012 to September 12, 2012, at the Tomah VA medical center of 24 percent for scheduled drugs (controlled substances) and a 36 percent rate for antidepressants. Records produced p. 1552. We expanded the time frame to January 1, 2011 through September 12, 2012, and found that the rates were 26 percent for scheduled drugs and 38 percent for antidepressants. Records reviewed, p. 13547. The rates for both time periods were significantly less than alleged by some witnesses interviewed. We also note that the chart reviews (Records produced, pp. 4201-4265) showed policies and procedures in place to monitor early refills such as requiring a police report if the medication was reported stolen. *See also,* Records produced, p. 6147-6148.

With regard to the 3-day early refill policy, our review of the prescription data cited above found 179 instances in which patients having prescriptions for controlled substances from Dr. Houlihan requested refills at the pharmacy window more than 3 days early during the period from January 1, 2011 through September 12, 2012 (median days early = 7), and 246 such instances for the nurse practitioner (median days early = 6). Records produced, pp. 12408-12430. Overall, the pharmacy window had to deal with 1,051 out of policy early refills from all providers. Thus, during the approximately 89 weeks evaluated, the pharmacy window dealt with nearly five out-of-policy refills per week from Dr. Houlihan and the nurse practitioner alone, and nearly 12 per week overall. This confirmed the impressions of dispensing pharmacists we interviewed that dealing with early refill requests was a daily occurrence. However, it did not confirm their perceptions that all or most patients were getting early refills.

Our administrative closure report includes a Table (p. 8) which shows the results of our analysis of the prescription practices for the 10 highest individual VISN 12 clinician prescribers. The Table shows a wide range in morphine equivalents prescribed per patient among the 10 highest prescribers. Dr. Houlihan was fourth and the nurse practitioner a distant second to the highest prescriber who was not at the Tomah VA medical center (63,184 morphine equivalent per unique patients v. 29,264 for the nurse practitioner). These findings were derived from the spreadsheets produced at 1946-2057, 2879-4129. As noted in the administrative closure p. 9, overall we concluded that the opioid prescribing by specified practitioners at the Tomah VA facility seemed unusually high.

While most of the pharmacists were concerned about the high doses of opioids, there was testimony indicating that part of the problem was that the pharmacists had no experience working with the complex medical/psychiatric issues facing the veterans at the Tomah VA medical center. One experienced pharmacist told us that "some of the pharmacists . . . they come out of school, they're young guys, they're clinical pharmacists, they're just set back by the quantities and the high doses on – on some of this. You know, and basically they – they go seek another job and eventually find one and they're gone." Records produced, p. 5340. The same individual testified that some psychiatrists use a lot of narcotics and some do not use any. The individual noted that Dr. Houlihan uses a lot and for him it was proper treatment. He also noted that the nurse practitioner prescribes a lot of narcotics because of the patients she has. Records produced, p. 5343. As noted in our administrative closure report, the patients were being treated for very complex medical and psychiatric conditions.

In an interview with a psychiatrist at the Tomah VA medical center, we asked about a specific patient of Dr. Houlihan's who was identified by multiple pharmacists as being overprescribed opioids and of suspected drug diversion. The psychiatrist had provided care to this individual during a hospital admission. When asked about this patient, the psychiatrist told us that the patient was on "very high doses" of pain medications. He told us that he assessed the patient and the patient's ability to function on the high doses ("not impaired in any way"), and confirmed that the patient was taking the opioids as prescribed. Records produced, pp. 5383-5384. The psychiatrist also noted that Dr. Houlihan treated the "most difficult adults in the hospital." Records produced, p. 5385. This patient was the only patient identified by multiple current and former pharmacists as being suspected of drug diversion. An investigation into this allegation, which included witness interviews, undercover surveillance, and review of evidence obtained via subpoena, did not substantiate the suspicions. Records produced, p. 1393

Based on our analysis of the prescribing practices, the patient records, and other information available to us, our expert psychiatrists and other physicians concluded in our administrative closure pp. 6-7, that the "appropriateness of prescribing opioids to a particular patient or the appropriateness of a particular dose utilized is a complex matter that must take into account the patient's history, current medical and psychiatric status, social situation, and other factors." Our experts further concluded that clinical decision making underlying this process is based on the

practitioner's clinical judgment and other factors that vary from patient to patient." As is evident from the interviews produced, particularly the interviews with past and present pharmacy staff, no one, other than Dr. Houlihan, the nurse practitioner, and other prescribing physicians had the requisite knowledge of the particular patients and their specific conditions to make these decisions.

More than one pharmacist told us that one of the problems was the lack of knowledge that the pharmacists have with the overall picture regarding each patient. One pharmacist told us: "the physician or provider certainly has, you know, the overall big picture of the patient, you know. We are part of the therapy, of course, you know, but sometime I look (inaudible) because we are dispensers of medicine (inaudible) portion that would fill, of course, with, you know . . . we're dispensers." Records produced, p. 6032. This point was emphasized during the interview of a pharmacist, with many years of experience at the Tomah facility, who, when asked to comment on the doctors' prescription histories advised, "there are some that are of course prescribing more than others, and I don't know ...if that's their treatment field." When specifically asked about Dr. Houlihan's practice, the pharmacist stated, "Dr. Houlihan uses a lot, and I know he thinks ... this is proper treatment. You know, I'm not judging if it is or not." The pharmacist also commented on the effect differing practice areas might have on the amount of narcotics a specific provider might prescribe. To illustrate his point the pharmacist discussed the practice of a nurse practitioner stating, "Basically she deals with these types of guys and that's all she deals with. So I mean, she's not going to be dealing with blood pressure or high cholesterol ... so she's prescribing a lot, but she's going to have to, because that's the type of patient she has." Records produced 5342-5343.

The inspection did not support allegations of drug diversion

While drug diversion was not identified as an issue being addressed in Senator Johnson's investigation, I believe it is worth discussing in this letter because a number of current and former employees, including Noelle Johnson, raised it in their interviews with the Healthcare inspectors. Although the issue was raised, none of the witnesses identified a specific patient who was known to be diverting drugs. As with other statements, the concerns were based on speculation, gossip, and rumors. The documents I submitted with my April 24, 2015, letter, included reports of contact with various law enforcement entities, including the Tomah police, who did not substantiate the allegations. Records produced, pp. 1549, 5726-5729. In addition, the records produced include an email from the VA Police at the Tomah facility that also did not substantiate the concerns raised by the individuals we interviewed.

On May 8, 2015, I provided a response to a request from Senator Johnson for information relating to cases of drug diversion that we investigated in Wisconsin and VISN 12. In my response, I reported that from January 1, 2008, to the present that we conducted six investigations in VISN 12 of which four cases were in Wisconsin. However, none of the cases

involved the Tomah VA medical center. I also reported that the cases involved 11 individuals of which seven were prosecuted. All subjects in those cases were employees, not veterans.

The VA OIG administrative closure did not address any tragedies or veterans deaths

In a February 11, 2015, email, Mr. David Brewer stated that the Chairman of the Committee had "directed [them] to examine the circumstances surrounding the tragedies at the Tomah VAMC" and Senator Johnson referred to "tragedies" in his statement at the March 26, 2015, hearing. As I explained in my February 27, 2015, letter to Senator Johnson, I do not know what tragedies he was referring to because the inspection, which was primarily conducted in 2012, did not include any deaths, and none were identified in the August 2011 complaint. Accordingly, I advised that our files did not include any records on this issue. I also stated in my February 27, 2015, letter that when we recently became aware of two specific deaths (August 2014 and January 2015) that were alleged to be related to poor quality care, we opened an investigation and an inspection to address these complaints. These activities are ongoing. Attached is a copy of my February 27, 2015, letter.

In his April 20, 2015, letter, Senator Johnson redefined the scope of his investigation stating that the "Committee is investigating allegations of veterans' deaths at the Tomah VAMC, retaliation against whistleblowers, and a culture of fear among employees at the facility that date back almost a decade." I addressed these issues in-depth in my April 24, 2015, letter and provided responsive records. I advised that because our Healthcare inspection did not address allegations of veterans' deaths at the Tomah VAMC, the file does not include any records responsive to this aspect of Senator Johnson's investigation. I also advised that if there is a specific death that Senator Johnson believes may have been brought to our attention during the review, to let me know and we will re-check our files. Neither I nor anyone on my staff received a request for documents or other information relating to a specific veteran's death or other such tragedy. I note that there are no records in our file for the 2011-2012 inspection relating to the death of a specific veteran due to poor quality care. Had we received such allegations, we would have reviewed the circumstances surrounding the death, including the care provided at the Tomah VA medical center.

The only specific death brought to our attention during the inspection was that of a psychologist, Christopher Kirkpatrick, who committed suicide after being terminated from his temporary position at the Tomah medical center on July 14, 2009. We did not find any evidence that Dr. Houlihan was in any way responsible for Dr. Kirkpatrick's death, although the Vice President of the local chapter of the American Federation of Government Employees (AFGE) expressed this opinion in documents she provided to the Juneau County Sheriff's Department who was responsible for investigating the suicide. I strongly recommend a thorough review of the in-depth Sheriff's report, a publicly available document, that is included in the documents produced, Records produced, pp. 5795-5851, with specific attention to the pages detailing the voluminous amounts and types of marijuana and what appears to be other illegal substances

found in Dr. Kirkpatrick's residence as well as other items, including a scale and used devices containing marijuana residue. The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana and other illegal substances. The Sheriff's report also lists large amounts of various prescription drugs found onsite, some of which were lying around loose with no indication whether they were prescribed for Dr. Kirkpatrick and, if so, when and by what provider.

Mr. Honl alleged in his written statement for the March 30, 2015, field hearing that "Dr. Kirkpatrick, who raised concerns about Dr. Houlihan's prescribing practices, was terminated, and went home and committed suicide." As previously noted, Mr. Honl was not employed by the VA in July 2009 when the event occurred and by his own admission has no personal knowledge of the death or the circumstances surrounding it. There is no evidence to support Mr. Honl's statement. Even the complaint from the Vice-President of the local AFGE, which is included in the Sheriff's report, does not allege that Dr. Kirkpatrick raised concerns about Dr. Houlihan's prescribing practices.

Retaliation for Whistleblowing

With respect to the issue of retaliation for whistleblowing, our inspection did not address this issue. Other than former Tomah VAMC pharmacist, Noelle Johnson, who testified at the field hearing held by Senator Johnson on March 30, 2015, in Tomah, Wisconsin, no one told us that they were retaliated against for whistleblowing nor did anyone identify a specific individual who was retaliated against for whistleblowing. Ms. Johnson has alleged both in her interview with VA OIG staff and in her testimony on March 30, 2015, that her termination from her position as a pharmacist at the Tomah VA medical center in June 2009 during her probationary period was in retaliation for whistleblowing because she would not fill a prescription. The evidence that we reviewed during the inspection does not support her assertion. We suggest that Committee Members review the document in the records produced, titled Agency's Pre-Hearing Submission, which relates to Ms. Johnson's appeal of her removal that she filed with the Merit Systems Protection Board (MSPB) (Submission). Records produced, pp. 4883-4899. This document addressed her her alleged whistleblowing including the fact that she went to the Office of Special Counsel which determined that she did not make a protected disclosure. More importantly, the document details the circumstances surrounding and reasons for her termination and refutes her assertion that she was fired for refusing to fill a prescription. This information is important because the transcripts of the interviews with numerous current and former pharmacy employees reflect a fear of Dr. Houlihan because of what they had heard about Ms. Johnson's termination, not their personal knowledge of the facts.

The Submission states that Ms. Johnson's first line supervisor recommended her termination because she had poor interpersonal skills and was caustic with clinicians. Her second line supervisor was expected to testify that Ms. Johnson had repeated negative interactions with clinicians and that he met with her concerning these issues. After the second level supervisor left

for a military deployment, the individual who was acting in that position was expected to testify at the hearing that she rated Ms. Johnson's performance as unsatisfactory in June 2009 based on complaints by the first level supervisor, provider complaints, and Ms. Johnson's unwillingness to be a team player. This rating resulted in Ms. Johnson's removal. Dr. Houlihan was identified in the Submission as a witness but his proposed testimony was limited to his interactions with Ms. Johnson, not the decision to remove her. Records produced, pp. 4883-4898.

I also refer you to the transcript of our interview with Ms. Johnson's first level supervisor who told us that Ms. Johnson was having a hard time and "she brought a lot of negativity back into the department and there were some people who didn't agree with her at first and so that created friction." Records produced, p. 6009. He further stated that one of the problems they had with Ms. Johnson was that "it was her way or the highway, but she didn't have that kind of authority, but if you didn't agree with her you were obviously less intelligent than her. . . . That's why she became difficult to work with in committees because if you disagreed with her you obviously were not as intelligent as her and that kind of rolled into the pharmacy too where people were siding with her or siding against her, and that was kind of driving it down a different path." *Id.*

Contrary to statements by Ms. Johnson and the perceptions of several witnesses interviewed during our review, some of whom were not even employed at the Tomah VA medical center when Ms. Johnson's employment was terminated, the records available to us during our review do not support the conclusions that Dr. Houlihan fired Ms. Johnson, that she was fired in retaliation for whistleblowing or that she was fired for refusing to fill a prescription. It must be noted that at the time, Ms. Johnson was not only a probationary employee, she also had just completed her training and this was her first position as a pharmacist.

Culture of Fear

The third issue identified as being within the scope of Senator Johnson's investigation is the "culture of fear that dates back for almost a decade." Our Healthcare inspection did not address this specific issue. While it is true that some individuals expressed that they had some level of fear, the transcripts of the interviews show that it was based primarily on gossip, rumor, and hearsay, not personal experiences or fact. As discussed above, a number of witnesses cited the removal of Ms. Johnson as the basis for their fear of Dr. Houlihan, which they believed was based on her refusal to fill a prescription. For example:

- One pharmacy employee told us "there was kind of urban legends of other pharmacists leaving because their voices weren't being heard." Records produced, p. 5095.
- Another, who had worked at a community based outpatient clinic affiliated with the Tomah VA medical center, was critical of Dr. Houlihan because she heard that he blamed her for the death of a patient who committed suicide in 2010 after she refused to provide an early refill for a patient who subsequently committed suicide. However, she did not discuss the matter with Dr. Houlihan and told us that she "tried to stay as far

away from him because of what Noelle Johnson went through with him, the pharmacist that he fired over her refusing to fill narcotic prescriptions." Records produced, pp. 5047-5048. When pressed for more information, the individual admitted that she didn't "know the details" and suggested that we speak with Noelle Johnson. Records produced, p. 5054. Although the pharmacist said that she was aware that Dr. Houlihan was upset with the decision she made and told us (in 2012) that "he was out to get her" for the 2010 incident, she admitted that no action was taken against her. Records produced, p. 5051.

- Another pharmacy employee told us that he did not question things because he was "scared to question it." Records produced, p. 5483. When asked why he was afraid, the individual told us: "Well, right before I came here as a student, a pharmacist was let go and basically, you know, I wasn't here for it, but everybody has told me that she was let go because she questioned a prescription from Dr. Houlihan and he basically found a way to release her." *Id.*
- Another pharmacist told us: "If I piss off the wrong people I'm gone and there's been stories that a pharmacist here a few years ago that was not playing ball was gone." Records produced, 6036.

The fact is that although some witnesses expressed concern over what they feared Dr. Houlihan would do if they questioned him or another provider, it is clear from the interviews that staff did raise questions and that no one was subjected to any disciplinary or performance based action for doing so. In summary, the current or former employees who expressed fear of Dr. Houlihan all worked in the pharmacy, did not have any direct negative personal experiences with Dr. Houlihan, and had no personal knowledge regarding Ms. Johnson's removal. Accordingly, their fears were not based on personal experience or personal knowledge of the facts and were unsupported by fact. As we stated in the administrative closure report p. 5, "In the context of having obtained multiple contradictory facts and statements during the course of this inspection, often based on second or third hand accounts, we did not substantiate allegations of abuse of authority, intimidation and retaliations when staff questioned controlled substance prescription practices."

During her interview, Ms. Johnson related interactions between her and Dr. Houlihan in which she stated that he yelled and used profanity towards her. No other witness related any similar conduct on the part of Dr. Houlihan. One witness indicated that Dr. Houlihan would raise his voice and yell, but did not tell us that Dr. Houlihan used profanity. Records produced, pp. 5995, 5998. Another witness interviewed in 2012 described one meeting in which Dr. Houlihan yelled but also stated that he had calmed down a lot. Records produced, p. 6052. In contrast, other witnesses, including personnel in pharmacy, told us that they had positive interactions with Dr. Houlihan. One pharmacist denied any inappropriate behavior by Dr. Houlihan and told us that he had to call him a couple of times with concerns and that he "is quite nice in the way he gets his point across and all that" and "he is not a rude person at all." Records produced, p. 5499. A

pharmacist who was in a supervisory position and working with Dr. Houlihan daily at the time of our site visit described his working with Dr. Houlihan as "fine" and stated that "It's no challenge at all." Records produced, p. 6143. A physician related to us that when he got to the Tomah VA medical center, he noticed a "handful of staff talked about Dr. Houlihan in a way that sounded at the time a little unbalanced and paranoid…It sounded as if he were doing all kinds of things and it was never very specific." Records produced, p. 5352. The physician discussed concerns raised by the manager of the residential programs who talked about Dr. Houlihan as if "there wasn't any faith in him" and that the individual had said "you can't trust him. Be careful around him." However, the physician added that the individual making these statements was "never specific." *Id.* This physician told us that in his experience, Dr. Houlihan knows the patients and "has been quite reasonable as far as the concerns have been," *Id.* He volunteered that "We have no belief that he deliberately gives veterans something or did anything criminal. He has been very receptive to people and to veterans." *Id. See also,* pp. 6068- 6069, 6130, 6132, 6148, 6150, 6165-6166. Another psychiatrist told us that he does not prescribe opioids because he was not trained to do that and that he has not felt any pressure from his supervisors to prescribe opioids. Records produced, p. 5382. When asked about his interactions with Dr. Houlihan, the psychiatrist stated that Dr. Houlihan was a resource for him and that he found him very approachable. He stated that Dr. Houlihan hired him, that that he did not "have a problem picking up the phone and talking to him . . .," and that he "encouraged [his] colleagues to do the same. Don't be afraid." Records produced, 5382-5383.

The August 2011 anonymous complaint cited an incident in which Dr. Houlihan interfered with the arrest of one of his patients by the police on the Tomah campus. As noted above, during an interview with VA OIG Office of Healthcare Inspections and Criminal Investigations personnel, the individual acknowledged sending the letter. When asked to provide more detail, including the identity of the police officer, she was unable to do so. When initially asked, the individual said "That's what this guy told me," but did not identify the "guy." When pressed for more information, the individual stated, "If I got my story right, you know. I'm just trying to go from memory" . . . "But I'm pretty sure that's what he said." Records produced, p. 5326. *See also,* pp. 5321, 5325. Despite multiple attempts to identify the police officer or obtain other information from the Tomah police and the VA police onsite at the facility, we were unable to substantiate that the incident alleged in the August 2011 complaint actually occurred. A witness knowledgeable regarding law enforcement activities at the Tomah VA medical center denied any interference by Dr. Houlihan with law enforcement activities or the reporting of concerns to the VA OIG. He also denied that Dr. Houlihan crossed any boundaries with regard to law enforcement. Records produced, pp. 6130-6132.

We recognized during the inspection that there was friction between the pharmacy and the providers, not just Dr. Houlihan, particularly with regard to early refills and what some perceived as over prescribing of opioids. We noted in our administrative closure report p. 10, that we had a concern about the "dysfunction of multidisciplinary collaboration in patient care that we

observed, particularly between pharmacy staff and Dr. Z [Houlihan]. *Perceptions* of abuse of authority, intimidation and retaliation are problematic in themselves because they diminish or even preclude the willingness to communicate concerns about potential safety issues or aberrant patient behaviors. . .The pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. [Houlihan] or any aberrant behavior by his patients (for example, frequent requests for early refills because they feared reprisal, even though most of them could not give a first-hand account of negative actions towards them by Dr.[Houlihan]. For his part, Dr. [Houlihan] complained that the pharmacists, (except for one) were unwilling to approach him with problems or concerns and were uninterested in learning more about his treatment approach and rationale." (Emphasis added). To address this issue, we suggested to the facility Director and VISN management the "facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions."

Summary

We prepared this document to supplement the 13,949 pages of material that we provided in compliance with the Committee's subpoena. We would be happy to provide a briefing to any Committee Member on our work during 2011-2012, which is highlighted in this analysis.

We are working diligently to complete our work concerning the circumstances involving the deaths of Thomas Baer and Jason Simcakowski. Upon completion, we will be available to provide a briefing of our conclusions to the Committee.

Administrative Closure
Alleged Inappropriate Prescribing of
Controlled Substances and Alleged Abuse of Authority
Tomah VA Medical Center
Tomah, WI
MCI# 2011-04212-HI-0267

Background

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted a review to assess the validity of multiple allegations made by a series of complainants. Common elements among the concerns included alleged misprescribing and diversion of opioid drugs by a high ranking physician at the facility (Dr. Z) and by a [(b)(6)] ([(b)] Y), as well as abuse of administrative and clinical authority by Dr. Z. The various allegations were compiled from:

- A complaint made in March, 2011 by a facility [(b)(6)] (with a corresponding VISN response in June, 2011 and a September, 2011 report from the VISN Chief Medical Officer (CMO) on remedial actions taken).
- Anonymous complaints made in August, 2011, via a letter sent to the OIG and Congressman Ron Kind of the U.S. House of Representatives.
- A physician at the facility in March, 2012, while the inspection was actively ongoing.

By several anonymous respondents to an EAR survey in May, 2012, that was conducted prior to a regularly scheduled CAP inspection. A total of 32 specific allegations were made by these sources, several of which came to light at various points while the inspection was underway.

The scope of our review included the assessment of the practice patterns and controlled substance prescribing habits of Dr. Z and [(b)] Y, as well as the administrative interactions of Dr. Z with subordinates and his approach to clinical leadership, specifically as these related to issues around the prescribing of controlled substances. We also looked for any concerns by Federal and municipal law enforcement authorities or other signals of drug diversion related to the practices of Dr. Z and [(b)] Y. Because of the potential seriousness of the allegations and their origination from multiple sources, we performed an

exhaustive review of the individual practitioners named. Because of the allegations of criminal activity, our efforts throughout this inspection were closely coordinated with the OIG's Criminal Investigation Division (51).

We reviewed documents from VA and non-VA sources as follows:

1. Statement of Charges, Settlement Agreement and Final Order from a state Medical Board concerning charges brought against Dr. Z shortly after his date of appointment to the VA.
2. Letters from the Veterans Integrated Service Network (VISN) 12 Director and the VISN 12 CMO.
3. Five peer reviews, and correspondence from Dr. Z to the Peer Review Oversight Committee and the VISN 12 regarding allegations made in March, 2011, and subsequent actions by VA management.
4. Scope of practice documents and routine peer reviews for (b)(6) Y.
5. OIG Master Case Index records of 19 cases at Tomah VAMC since 2009.
6. Ten peer reviews of Dr. Z's practice performed in November, 2009, along with minutes of a subsequent special session of the Peer Review Committee, and related correspondence between Dr. Z and the Committee.
7. Tomah VAMC police reports of overdoses/suspected overdoses for a three-year period.
8. Reports on adverse drug reactions in patients treated by Dr. Z and (b)(6) Y compiled by the Tomah VAMC pharmacy.
9. Documents related to the suicide of a Tomah VAMC (b)(6) professional immediately following termination of employment (memoranda, e-mail messages, Sheriff's Department reports, union representation records and related internal union correspondence).
10. Documents related to the appeal of a terminated Tomah VAMC (b)(6) to the Merit Systems Protection Board (MSPB) (appellant's brief for MSPB jurisdiction, narrative of (b)(6) experiences, supporting materials for decisions).
11. Relevant Medical Center Memoranda on pain management, chronic opioid use, and adverse drug event surveillance.
12. VA/DoD Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain (May, 2010).

We also requested Tomah VAMC police reports on sales of prescribed or illegal drugs on the Tomah VAMC campus in the preceding three years, but were told there have been no Uniform Offense Reports of such activities.

We conducted general chart reviews as follows:

1. Patients who were specifically identified in complainants' allegations.
2. Patients who were included in June, 2011, peer reviews of Dr. Z's practice.
3. A patient of (b)(6) Y who was identified by an informant to Tomah municipal police as being involved in drug diversion.
4. Selected individuals from a list of the 100 patients at Tomah VAMC receiving the highest doses of opioids

We also performed structured chart reviews and compiled the results using a SharePoint®-based data entry tool and Microsoft Excel® spreadsheet as follows:

1. All patients in the care of Dr. Z and/or (b)(6) Y who were among the 100 patients at Tomah having the highest doses of opioids (32 cases).
2. Patients on a list provided by the Tomah municipal police department of individuals suspected of drug crimes, who were receiving prescriptions for controlled substances from any provider at Tomah (24 cases; 15 were patients of Dr. Z and/or (b) Y).

We collected an e-mail dataset for review consisting of 227,532 unique e-mail messages and 859 associated files originating from 17 individuals. This review was performed using Clearwell software. We searched terms that could signal potential drug seeking behavior, such as those related to early refills and urine drug screens, in order to assess what was being communicated about these topics, as well as what advice or instructions were being given. We also reviewed messages pertaining to specific individuals in cases where administrative/supervisory conflicts were reported to exist.

We reviewed several extensive Microsoft Excel®-based datasets derived from pharmacy records with assistance from the VISN 12 Pharmacy Executive as follows:

1. Early refills of controlled substances and antidepressants (for comparison) at Tomah VAMC over the period of January 1, 2011 to September 12, 2012.
2. Total morphine equivalent amounts of opioids dispensed during FY 2012 in all VISN 12 facilities by site, provider, and patient.

We conducted telephone interviews prior to a site visit, including:

1. The complainant in the case where he/she was not anonymous.
2. Tomah and Milwaukee municipal police officials; a Diversion Investigator from the Drug Enforcement Administration (DEA), United States Department of Justice.
3. Current and former Tomah VAMC staff who were identified by complainants as having key information, including a (b)(6) a physician, and four pharmacists.
4. The newly appointed Director of Tomah VAMC.

We also engaged the assistance of three pharmacist consultants to assist us in evaluating the clinical and administrative aspects of Dr. Z's interactions with pharmacy staff and the staff's roles in facilitating patient safety and appropriately dispensing controlled substances. We provided the consultants with access to recordings of the interviews with the four pharmacists who had previously left Tomah VAMC.

We conducted a site visit at the facility on from August 22-23, 2012 -12. We interviewed the Associate Director (the Director was on sick leave), the Chief of Staff, the Mental Health Associate Chief of Staff, the Chair of the Pharmacy and Therapeutics Committee, the Director of the facility's Opioid Workgroup, the facility's Police Chief, the Pharmacy Director, the Outpatient Pharmacy Supervisor, two clinical pharmacists, six outpatient staff pharmacists, one contract dispensing pharmacist, three psychiatrists, two primary care physicians, a physician's assistant, a (b)(6) specialist, Dr. Z, and (b) Y,

During the site visit, we toured the outpatient pharmacy to assess security issues that had been raised in interviews. We also met with the Acting Chief Information Officer to discuss obtaining e-mail files that we were unable to retrieve remotely.

Following the site visit, we conducted several additional interviews by telephone as follows: the Medical Center Director, the Director of Human Resources, and the VISN Pharmacy Executive.

Findings

We did not substantiate allegations that the Tomah municipal and Milwaukee police departments made complaints about drug trafficking at the Tomah VAMC. However, the Tomah police department reported suspicions that certain Tomah VAMC patients were

misusing their prescribed controlled substances in various ways including drug diversion.[1]

We substantiated the allegation that at least five outpatient pharmacy staff left the facility in recent years. Pharmacists reported various reasons for leaving. The four pharmacists whom we interviewed expressed concerns regarding the facility's (and ultimately Dr. Z's) expectations for dispensing opioids and other controlled substances. One pharmacist, a new employee, was not retained by the facility at the conclusion of his/her initial employment period. This individual reported that on three occasions he/she had refused to fill prescriptions for controlled substances due to concerns about patient safety and/or drug diversion. A second clinical pharmacist who left the Tomah VAMC reported feeling inappropriately blamed by Dr. Z for the suicide of a patient. A dispensing pharmacist, relatively new to the facility, reported that he believed there were 40-50 patients who were regularly presenting to the outpatient pharmacy for early refills of opioids, and that pharmacists were told by Dr. Z they had to fill the prescriptions. He feared this would place his license at risk. A clinical pharmacist who had been hired in a supervisory capacity reported that when some of the pharmacists expressed discomfort with dispensing high doses of opioids to patients, Dr. Z would become angry and would insist that this pharmacist discipline the other pharmacists under his supervision.

We did not substantiate the allegation that Dr. Z was mismanaging a patient with complex regional pain syndrome by attempting to arrange an inappropriate above the knee amputation.

In the context of having obtained multiple contradictory facts and statements during the course of this inspection, often based on second or third hand accounts, we did not substantiate allegations of abuse of authority, intimidation and retaliation when staff question controlled substance prescription practices.

While we did not substantiate the allegations of abuse of authority, intimidation and retaliation when staff question controlled substance prescription practices, we did find that these are widely held beliefs and concerns among most pharmacy staff and among some other staff.

[1] Additionally, during the course of their investigations of a few deceased veterans they had noted large quantities of prescribed controlled substances in their (the veterans') residences. However, no law enforcement actions were being taken. Early in this inspection we became aware that the DEA was actively investigating complaints of inappropriate prescribing and drug diversion at the Tomah VAMC.

We found that the Chief of Pharmacy reports to Dr. Z by virtue of his (Dr. Z's) administrative leadership position.

We found that some patients at Tomah VAMC had a pattern of early refill requests, which can be a potential risk behavior for substance abuse. Pharmacists expressed a reluctance to question such early refills. Review of a VISN 12 pharmacy leadership data analysis indicated that Dr. Z, (b) Y, and other clinicians at the Tomah VAMC provided more than 7 days early controlled substance refills. A pre-April 12, 2012, local facility policy did not allow exceptions to the "no early refill" rule. A newer policy does not prohibit exceptions but does not provide practical guidance, parameters, or processes by which to approach early refills or navigate the clinical complexity of such exceptions.

We substantiated the allegation that negative urine drug screens (UDS) are not acted on and that controlled substances are still prescribed in the face of a negative UDS. In the course of our review of selected case histories and from the structured medical record review, we found that for some patients, when a UDS was performed and showed absence of prescribed medication, documentation in progress notes did not always acknowledge this or indicate what, if any, clinical intervention or change in treatment was initiated with the patient. For example, we found in a general chart review of a selected case treated by (b)(6) Y that multiple negative UDS (i.e., UDS that did not show presence of prescribed medications) were not acted on. In our structured medical record review, 52 of 56 patients had UDS performed at least one time between January, 2009, and April, 2012. The remaining four patients had no UDS performed during this time interval spanning more than three years, although all were treated chronically with opioids during this period. Of the 52 patients who had UDS performed at least one time between January, 2009, and April, 2012, there were five patients who were being prescribed opioids at the time of the negative test, i.e., the test failed to confirm that they were actually taking their prescribed medication.

We did not substantiate the allegation that opioid contracts are not being "encouraged" by Dr. Z. We found that 48 of 56 patients in the structured medical record review had an opioid contract. Of the patients lacking opioid contracts, Dr. Z was a primary prescriber of opioids for none, and (b) Y was a primary prescriber of opioids for two.

Several allegations dealt with general over prescription of narcotics at the facility, and specifically alleged over prescription by Dr. Z and (b)(6) Y. The appropriateness of prescribing opioids to a particular patient or the appropriateness of a particular dose utilized is a complex matter that must take into account the patient's history, current

medical and psychiatric status, social situation, and other factors. The clinical decision making underlying this process is based on the practitioner's clinical judgment and other factors that vary from patient to patient. In this context, we did not substantiate the allegations that opioids were prescribed inappropriately to specific individuals or in inappropriate doses.

However, based on the analysis depicted in Tables 1 and 2 below, we determined that the amounts of opioids prescribed by Dr. Z and (b)(6) Y in aggregate and to individual patients were at considerable variance compared with most opioid prescribers in VISN 12. Table 1 below shows prescription drug data prepared by VISN 12.

Table 1. Morphine Equivalents Prescribed by each VISN 12 VAMC Station in FY 12.

Station	Total Morphine Equivalents	Unique Patients with Opioid Prescriptions	Total Morphine Equivalents/Unique Patients with Opioid Prescriptions	Average Daily Morphine Equivalents Dispensed (Total Morphine Equivalents/365 days)
676[2]	36,845,093	3171	11,619	100,945
585	28,974,019	3570	8,116	79,381
578	66,814,245	9144	7,307	183,053
607	42,341,117	5893	7,185	116,003
556	21,668,793	3390	6,392	59,367
695	51,990,679	9888	5,258	142,440
537	42,127,193	8662	4,863	115,417

As shown in Column 1 for FY 12, the range among VISN 12 facilities for total morphine equivalents was 21,668,793 to 66,814,245. Tomah was ranked 5th (highest to lowest) of the seven facilities in VISN 12. Column 2 indicates that the facility has the smallest number of patients treated with opioids, which in part may reflect the smaller size of the overall patient population at the facility relative to larger facilities in VISN 12. Column 3 indicates the total morphine equivalents per unique patients treated with opioids. Tomah VAMC ranks highest in this category.[3]

VISN 12 provided similar data on a provider level for providers throughout VISN 12. For total morphine equivalents prescribed in FY 12, (b)(6) Y was highest in the VISN

[2] Tomah VAMC

[3] It is possible that these numbers may not be directly comparable since larger facilities with more extensive surgical and emergency treatment services likely have more patients that are treated acutely for short time frames with smaller opioid doses. However, data presented suggest this may not be the entire explanation. It can be conclusively stated from Table 1 is that the total amount of opioids prescribed in aggregate at the Tomah VAMC is in the middle range compared with other VISN 12 facilities.

among 3206 providers who wrote prescriptions for opioids. Dr. Z was the seventh highest opioid prescriber in VISN 12, and a (b)(6) at Tomah VAMC was the fifth highest prescriber. These three providers accounted for 33.3% of all morphine equivalents prescribed at Tomah VAMC in FY 12.

Table 2. Ten highest individual VISN 12 clinician prescribers (by morphine equivalents) in FY 12

Equivalence Determined by Total Quantity Dispensed in FY12				
Station	TotalMorphEquiv	UniquePats	TotalMorphineEquiv	AveDailyMeqDispensed
			Total Morph Eq/Unique Rx Pts	Total Morph Eq/365 Days
676 (b)(6) Y)	5,326,011	182	29,264	14,592
585	4,213,089	366	11,511	11,543
578	4,162,684	271	15,360	11,405
537	3,810,090	311	12,251	10,439
676 (b)(6))	3,734,272	332	11,248	10,231
585	3,489,265	340	10,263	9,560
676 (Dr. Z)	3,218,188	128	25,142	8,817
578	3,159,204	50	63,184	8,655
556	2,721,641	107	25,436	7,457
695	2,427,161	270	8,989	6,650

Data for the ten highest individual prescribers in the VISN are shown in Table 2. Considering these ten highest prescribers, three were from Tomah VAMC, while two other facilities had two providers each, and the remainder had one or none. Among these ten highest prescribers in the VISN, the total morphine equivalents prescribed for the one year period ranged from 2,427,161 to 5,326,011 morphine equivalents, and morphine equivalents per unique patient ranged from 8,989 to 63,184.[4] Thus, even among these ten highest individual prescribers, there was considerable variation in amounts prescribed; the total morphine equivalents prescribed by (b)(6) Y was more than double that prescribed by the tenth highest prescriber in the VISN, and morphine equivalents per unique patient was more than threefold higher.

On a per patient basis, (b)(6) Y prescribed 29,264 morphine equivalents per patient (second highest among VISN 12 clinicians) during FY 12; for Dr. Z, the number was comparable (25,142; fourth highest among VISN 12 clinicians). Patient populations can vary from facility to facility, complexity of patient case mix can vary from provider to provider, and individual patient characteristics and needs vary from patient to patient. Nevertheless, it seems clear that the total amount of opioid and opioid per patient prescribed by (b)(6) Y and

[4] Because of continuing public interest, the OIG decided to publish this report in February 2015. In preparing the report for publication, we identified an error in this sentence; we originally reported the range as 8,989 to 29,264. We corrected the report for publication.

Dr. Z are at considerable variance compared with most opioid prescribers in VISN 12, and the data support that total opioid prescribing for one additional individual prescriber at the facility is likewise unusually high.

We did not substantiate the allegation that "Opioids are contraindicated for PTSD, but this is part of [Dr. Z's] treatment plan." In review of patient medical records, emails, and during the course of our interviews we did not find documentation that opioids were being used to treat PTSD. In each case, medical record review indicated a history of a pain related condition and use of opioids for treatment of pain.

At the time of our site visit, Tomah VAMC leadership reported that a Pain Management Committee met on a monthly basis. The Committee was co-chaired by (b)(6) Y and a primary care physician with a background in pain management. Other members included another physician with a background in pain management, Dr. Z as an adjunct member, a (b)(6) One co-chair told us that the Committee addresses mainly administrative issues but that individual clinical cases were addressed by a smaller group of clinicians. This smaller group consisted of (b)(6) Y, the (b)(6) and possibly a member of nursing staff not affiliated with the committee. An opioid work group was in the process of being formed. The focus of the work group was to establish surveillance of clinician prescribing patterns. The planned work group included the members of the Pain Management Committee with the addition of the Director of Pharmacy.

Summary and Conclusions

We did not substantiate the majority of allegations made in the various complaints that OIG received. Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they do not constitute proof of wrongdoing. We did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies.

Nevertheless, our inspection raised potentially serious concerns that should be brought to the attention of VISN 12 management for further review. In particular, we noted that the amounts of opioid equivalents prescribed by Dr. Z and (b)(6) Y, both in aggregate and per individual patient, were at considerable variance compared with most opioid prescribers in the VISN, and that a Tomah VAMC (b)(6) was likewise prescribing an unusually high total opioid amount. Additionally, while it is true that certain clinicians may be treating patients with unusual conditions that require unconventional treatments,

it would seem more clinically appropriate for such complex patients to be treated by a specialist or subspecialist in their particular condition, rather than a (b)(6) or (b)(6)

Also of concern was the dysfunction of multidisciplinary collaboration in patient care that we observed, particularly between the pharmacy staff and Dr. Z. Perceptions of abuse of authority, intimidation and retaliation are problematic in themselves because they diminish or even preclude the willingness to communicate concerns about potential safety issues or aberrant patient behaviors. From a systems perspective, facility leadership, staff, and ultimately patients and their safety, benefit when there is an environment of communication, collaborative care, approachability, and functional checks and balances. When effective, such collaboration provides a system of checks and balances that reduces medication errors and enhances general patient safety, and is especially important in this setting given the quantities and dosage of opioids that are being utilized in seriously ill patients. The facility appeared to be at a functional impasse with respect to such collaboration. The pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. Z or any aberrant behavior by his patients (for example, frequent requests for early refills) because they feared reprisal, even though most of them could not give a first-hand account of negative actions toward them by Dr. Z. For his part, Dr. Z complained that pharmacists (except for one) were unwilling to approach him with problems or concerns and were uninterested in learning more about his treatment approach and rationale

The Chief of Pharmacy reporting to Dr. Z by virtue of Dr. Z's administrative leadership position may complicate the perception that Dr. Z misuses his authority to compel acquiescence with his clinical decisions.

For patients with complex oncology problems, hospitals often have committees known as tumor boards, comprised of clinicians from multiple disciplines (oncology, surgery, radiation oncology, nursing, nutrition among others) that convene periodically to discuss and recommend an integrated plan for patients with complex cases of cancer.

There are several suggestions that should be brought to the attention of the facility Director and VISN management, as follows:

- The facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions.

- The facility Director should review the reporting structure in the context of safeguarding bi-directional clinical discourse from actual or perceived administrative constraint.
- The facility Director should ensure development of guidance, parameters, processes, or a specialty clinic based mechanism to assist clinicians and staff with managing complex patients requesting early opioid refills.
- The facility Director should consider some variant of the tumor board model as one potential avenue by which to foster collaborative interdisciplinary management when presented with very complex clinical pain cases.
- The VISN should conduct further evaluation and monitoring of relative and case-specific opioid prescribing at Tomah VAMC on both a facility and individual clinician level.

I concur with the recommendation for administrative closure of this inspection. The material in this report will be briefed to VISN 12 Senior Staff including the VISN 12 Director and CMO, and to Tomah VAMC's Director. A report of contact from that briefing will be appended to this administrative closure.

Based on our review, I am administratively closing this case.

JOHN D. DAIGH, JR, M.D.
Assistant Inspector General for
Healthcare Inspections

3/12/14

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

February 25, 2015

The Honorable Richard J. Griffin
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Deputy Inspector General Griffin:

I write to express concerns about the operations and effectiveness of the Department of Veterans Affairs Office of the Inspector General (VA OIG). The Committee on Homeland Security and Governmental Affairs has been examining the tragedies that have occurred at the VA Medical Center (VAMC) in Tomah, Wisconsin. I am troubled that the VA OIG has refused to cooperate with the Committee's oversight of the Tomah VAMC, especially in light of the OIG's nonpublic review of the facility completed in 2014. I ask that you direct your office to cooperate with the Committee's ongoing oversight work.

Yesterday, the Committee heard testimony from four inspectors general who take seriously their obligations to oversee the executive branch and identify waste, fraud, and abuse.[1] These IGs effectively partner with congressional oversight committees to ensure that federal programs are run responsibly and taxpayer dollars are spent wisely. Moreover, they have a shared view of their duties as the independent watchdogs of their respective agencies.

The contrast between these IGs and your office is stark. In March 2014, your office completed a three-year healthcare inspection of opioid prescription habits and the work environment at the Tomah VAMC.[2] The VA OIG did not publicly release the eleven-page administrative closure at the time of its completion and it delayed reporting its findings to Congress. Amid calls for increased transparency on the Tomah VAMC investigation earlier this year, VA OIG finally publically released the March 2014 inspection on February 6, 2015.

Following the public release of this report, Committee staff sought to better understand the nature and scope of the VA OIG's review. On February 4, 2015, Committee investigators met with Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections, and Dr.

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[1] *"Improving the Efficiency, Effectiveness, and Independence of Inspectors General": Hearing before the S. Comm. on Homeland Sec. & Gov't Affairs*, 114th Cong. (2015).

[2] U.S. Department of Veterans Affairs, Office of Inspector General, Administrative Closure, Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority at the Tomah Medical Center, MCI# 2011-04212-HI-0267.

Alan Mallinger, Senior Physician in the Office of Healthcare Inspections.[3] During this meeting, Committee staff learned that the VA OIG compiled and still possesses a comprehensive investigative file gathered during its almost three-year investigation of the Tomah VAMC. Committee staff requested that the VA OIG produce the investigative file to the Committee to assist with the Committee's oversight work. Catherine Gromek, VA OIG's Congressional Relations Officer, indicated that the VA OIG would review the material and make it available to the Committee.

On February 11, 2015, after a phone call with Committee staff about the status of the documents, Ms. Gromek wrote to Committee staff: "We are going through the documents – of which there are many (we tend to gather a lot of information) – so let me discuss with our Release of Information Office staff about what a reasonable timeline could be for getting you the documents."[4] On February 13, 2015, Ms. Gromek e-mailed Committee staff requesting a meeting between the Committee and VA OIG attorneys about the documents.[5] Committee staff agreed to the meeting in an effort to facilitate the production of the investigative file.[6]

On February 18, 2015, two weeks after the Committee requested the VA OIG's investigative file pertaining to the Tomah VAMC, Committee staff met with VA OIG attorneys, including Maureen T. Regan, the Counselor to the Inspector General and Privacy Officer for the VA OIG.[7] During this meeting, Ms. Regan refused to cooperate with the Committee's oversight, questioning the Committee's authority and even the Committee's purpose for reviewing the work performed by the VA OIG. Ms. Regan stated that the VA OIG had no obligation to report to Congress outside of its semi-annual report. Ms. Regan implied that the VA OIG would not comply with the Committee's request and suggested that the VA OIG would need to seek the approval of the VA before producing certain material to the Committee.

When Committee staff asked Ms. Regan to discuss the types of documents contained in the investigative file to better understand the VA OIG's position, Ms. Regan refused to discuss the categories of documents. She refused to provide Committee investigators with a list of contents of the Tomah VAMC investigative file that she possessed during the meeting and to which she regularly referred. When asked whether the VA OIG's distribution of the March 2014 Healthcare Inspection of the Tomah VAMC was appropriate, she said she believed that the VA OIG was "transparent" in its release of the report.

The noncooperation of the VA OIG in the Committee's examination of the Tomah VAMC – as particularly exemplified by your chief counsel, Ms. Regan – is troubling. The Inspector General Act established inspectors general to assist Congress in its oversight duties by keeping "Congress fully and currently informed by means of [semi-annual reports] and *otherwise*" of "fraud and other serious problems, abuses, and deficiencies . . . ."[8] The refusal of

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[3] Meeting between Comm. staff & John Daigh & Alan Mallinger (Feb. 4, 2015).
[4] E-mail from Catherine Gromek to Comm. staff (Feb. 11, 2015).
[5] E-mail from Catherine Gromek to Comm. staff (Feb. 13, 2015).
[6] E-mail from Comm. staff to Catherine Gromek (Feb. 13, 2015).
[7] Meeting between Comm. staff & Catherine Gromek, Maureen T. Regan, & Darryl Joe (Feb. 18, 2015).
[8] 5 app. U.S.C. § 4 (emphasis added).

your office to comply fully and promptly with the Committee's oversight needlessly narrows and delays the Committee's examination of the tragedies that occurred at the Tomah VAMC.

Accordingly, I ask that you cooperate fully with the Committee's oversight of the Tomah VAMC. I request that you produce the VA OIG's entire investigative file pertaining to the Tomah VAMC no later than 5:00 p.m. on February 27, 2015. Because your staff has already acknowledged that it still possesses the entirety of the investigative file, I believe you could produce the material to the Committee without delay.

The Committee on Homeland Security and Governmental Affairs is authorized by Rule XXV of the Standing Rules of the Senate to investigate "the efficiency and economy of operations of all branches of the Government."[9] Additionally, S. Res. 253 (114th Congress) and S. Res. 73 (114th Congress) authorize the Committee to examine "the efficiency and economy of all branches of the Government including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement, incompetence, corruption, or unethical practices . . . ."[10] For purposes of responding to this request, please refer to the definitions and instructions in the enclosure. Thank you for your attention to this important matter.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Minority Member

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs

Enclosure

[9] S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).
[10] S. Res. 253 § 12, 113th Cong. (2013).

Instructions for Responding to a Committee Request

Committee on Homeland Security and Governmental Affairs
United States Senate
114th Congress

A. Responding to a Request for Documents

1. In complying with the Committee's request, produce all responsive documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, and representatives acting on your behalf. You should also produce documents that you have a legal right to obtain, that you have a right to copy or to which you have access, as well as documents that you have placed in the temporary possession, custody, or control of any third party. Requested records, documents, data, or information should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Committee.

2. In the event that any entity, organization, or person denoted in the request has been or is also known by any other name or alias than herein denoted, the request should be read also to include the alternative identification.

3. The Committee's preference is to receive documents in electronic form (i.e. CD, memory stick, or thumb drive) in lieu of paper productions.

4. Documents produced in electronic form should also be organized, identified, and indexed electronically.

5. Electronic document productions should be prepared according to the following standards:

    a. The production should consist of single page Tagged Image Files (".tif"), files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    b. Document numbers in the load file should match document Bates numbers and .tif file names.

    c. If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

    d. All electronic documents produced should include the following fields of metadata specific to each document:

    BEGDOC, ENDDOC, TEXT, BEGATTACH, ENDATTACH, PAGECOUNT, CUSTODIAN, RECORDTYPE, DATE, TIME, SENTDATE, SENTTIME, BEGINDATE, BEGINTIME, ENDDATE, ENDTIME, AUTHOR, FROM, CC, TO, BCC, SUBJECT, TITLE, FILENAME, FILEEXT, FILESIZE, DATECREATED, TIMECREATED, DATELASTMOD, TIMELASTMOD, INTMSGID, INTMSGHEADER, NATIVELINK, INTFILPATH, EXCEPTION, BEGATTACH.

e. Alternatively, if the production cannot be made in .tif format, all documents derived from word processing programs, email applications, instant message logs, spreadsheets, and wherever else practicable should be produced in text searchable Portable Document Format (".pdf") format. Spreadsheets should also be provided in their native form. Audio and video files should be produced in their native format, although picture files associated with email or word processing programs should be produced in .pdf format along with the document it is contained in or to which it is attached.

f. If any of the requested information is only reasonably available in machine-readable form (such as on a computer server, hard drive, or computer backup tape), consult with the Committee staff to determine the appropriate format in which to produce the information.

6. Documents produced to the Committee should include an index describing the contents of the production. To the extent more than one CD, hard drive, memory stick, thumb drive, box or folder is produced, each CD, hard drive, memory stick, thumb drive, box or folder should contain an index describing its contents.

7. Documents produced in response to the request should be produced together with copies of file labels, dividers or identifying markers with which they were associated when the request was served.

8. When producing documents, identify the paragraph in the Committee's schedule to which the documents respond.

9. Do not refuse to produce documents that any other person or entity also possesses non-identical or identical copies of the same documents.

10. This request is continuing in nature and applies to any newly discovered information. Any record, document, compilation of data or information not produced because it has not been located or discovered by the return date, should be produced immediately upon subsequent location or discovery.

11. All documents should be Bates-stamped sequentially and produced sequentially. Each page should bear a unique Bates number.

12. Two sets of documents should be delivered, one set to the Majority Staff and one set to the Minority Staff. When documents are produced to the Committee, production sets should be delivered to the Majority Staff in Room 340 of the Dirksen Senate Office Building and the Minority Staff in Room 344 of the Dirksen Senate Office Building.

13. If compliance with the request cannot be made in full by the date specified in the request, compliance should be made to the extent possible by that date. Notify Committee staff as soon as possible if full compliance cannot be made by the date specified in the request, and provide an explanation for why full compliance is not possible by that date.

Instructions for Responding to a Committee Request

14. In the event that a document is withheld on the basis of privilege, provide a privilege log containing the following information concerning any such document: (a) the privilege asserted; (b) the type of document; (c) the general subject matter; (d) the date, author and addressee; and (e) the relationship of the author and addressee to each other.

15. If any document responsive to this request was, but no longer is, in your possession, custody, or control, identify the document (stating its date, author, subject and recipients) and explain the circumstances under which the document ceased to be in your possession, custody, or control.

16. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, produce all documents which would be responsive as if the date or other descriptive detail were correct.

17. In the event a complete response requires the production of classified information, provide as much information in unclassified form as possible in your response and send all classified information under separate cover via the Office of Senate Security.

18. Unless otherwise specified, the period covered by this request is from January 1, 2009 to the present.

19. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Committee.

B. Responding to Interrogatories or a Request for Information

1. In complying with the Committee's request, answer truthfully and completely. Persons that knowingly provide false testimony could be subject to criminal prosecution for perjury or for making false statements. Persons that knowingly withhold requested information could be subject to proceedings for contempt of Congress. If you are unable to answer an interrogatory or information request fully, provide as much information as possible and explain why your answer is incomplete.

2. In the event that any entity, organization, or person denoted in the request has been or is also known by any other name or alias than herein denoted, the request should be read also to include the alternative identification.

3. Your response to the Committee's interrogatories or information requests should be made in writing and should be signed by you, your counsel, or a duly authorized designee.

Instructions for Responding to a Committee Request

4. When responding to interrogatories or information requests, respond to each paragraph in the Committee's schedule separately. Clearly identify the paragraph in the Committee's schedule to which the information responds.

5. Where knowledge, information, or facts are requested, the request encompasses knowledge, information or facts in your possession, custody, or control, or in the possession, custody, or control of your staff, agents, employees, representatives, and any other person who has possession, custody, or control of your proprietary knowledge, information, or facts.

6. Do not refuse to provide knowledge, information, or facts that any other person or entity also possesses the same knowledge, information, or facts.

7. The request is continuing in nature and applies to any newly discovered knowledge, information, or facts. Any knowledge, information, or facts not provided because it was not known by the return date, should be provided immediately upon subsequent discovery.

8. Two sets of responses should be delivered, one set to the Majority Staff and one set to the Minority Staff. When responses are provided to the Committee, copies should be delivered to the Majority Staff in Room 340 of the Dirksen Senate Office Building and the Minority Staff in Room 344 of the Dirksen Senate Office Building.

9. If compliance with the request cannot be made in full by the date specified in the request, compliance should be made to the extent possible by that date. Notify Committee staff as soon as possible if full compliance cannot be made by the date specified in the request, and provide an explanation for why full compliance is not possible by that date.

10. In the event that knowledge, information, or facts are withheld on the basis of privilege, provide a privilege log containing the following information: (a) the privilege asserted; (b) the general subject matter of the knowledge, information, or facts withheld; (c) the source of the knowledge, information, or facts withheld; (d) the paragraph in the Committee's request to which the knowledge, information, or facts are responsive; and (e) each individual to whom the knowledge, information, or facts have been disclosed.

11. If a date or other descriptive detail set forth in this request is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, provide the information that would be responsive as if the date or other descriptive detail was correct.

12. In the event a complete response requires the transmission of classified information, provide as much information in unclassified form as possible in your response and send all classified information under separate cover via the Office of Senate Security.

13. Unless otherwise specified, the period covered by this request is from January 1, 2009 to the present.

Instructions for Responding to a Committee Request

C. Definitions

1. The term "document" in the request or the instructions means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records, notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, inter-office and intra- office communications, electronic mail (e-mail), contracts, cables, notations of any type of conversation, telephone call, meeting or other communication, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto), and graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, microfilm, videotape, recordings and motion pictures), and electronic, mechanical, and electric records or representations of any kind (including, without limitation, tapes, cassettes, disks, and recordings) and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "communication" in the request or the instructions means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face to face, in meetings, by telephone, mail, telex, facsimile, email (desktop or mobile device), computer, text message, instant message, MMS or SMS message, regular mail, telexes, discussions, releases, delivery, or otherwise.

3. The terms "and" and "or" in the request or the instructions should be construed broadly and either conjunctively or disjunctively to bring within the scope of this subpoena any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

4. The terms "person" or "persons" in the request or the instructions mean natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures, proprietorships, syndicates, or other legal, businesses or government entities, and all subsidiaries, affiliates, divisions, departments, branches, or other units thereof.

5. The term "identify" in the request or the instructions, when used in a question about individuals, means to provide the following information: (a) the individual's complete name and title; and (b) the individual's business address and phone number.

Instructions for Responding to a Committee Request

6. The terms "referring" or "relating" in the request or the instructions, when used separately or collectively, with respect to any given subject, mean anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with or is pertinent to that subject in any manner whatsoever.

7. The term "employee" in the request or the instructions means agent, borrowed employee, casual employee, consultant, contractor, de fact employee, independent contractor, joint adventurer, loaned employee, part-time employee, permanent employee, provisional employee or subcontractor.

8. The terms "you" and "your" in the request or the instructions refer to yourself; your firm, corporation, partnership, association, department, or other legal or government entity, including all subsidiaries, divisions, branches, or other units thereof; and all members, officers, employees, agents, contractors, and all other individuals acting or purporting to act on your behalf, including all present and former members, officers, employers, agents, contractors, and all other individuals exercising or purporting to exercise discretion, make policy, and/or decisions.

# # #

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

February 27, 2015

The Honorable Ron Johnson
United States Senate
Chairman, Committee on Homeland Security and
Governmental Affairs
Washington, DC 20510-6250

Dear Chairman Johnson:

This is in response to your February 25, 2015, letter requesting the investigative file relating to work we have conducted in Tomah, Wisconsin. I note that this is the first request for the investigative file that I have received from you and the first request we have ever received from any Member of the Committee on Homeland Security and Governmental Affairs (Committee). The only prior request for these records was a verbal request by a Committee staffer after my staff provided Committee staff with an in-depth briefing on our work at Tomah. This verbal request was followed by an email from the same individual. As a point of clarification, the file requested consists largely of documents obtained or created by the Office of Inspector General's Office of Healthcare Inspections, which conducts inspections, not investigations.

As discussed below, my staff has made the effort to discuss the matter with Committee staff to identify the particular need for the documents that you or your staff can articulate relating to a legitimate oversight purpose, but to no avail. We are and have always been prepared to accommodate oversight requests but we need to do so in a manner consistent with the institutional interests of the Office of Inspector General (VA OIG) and the Executive Branch in general.

Before addressing the request, I must address some factual inaccuracies in your letter relating to the Tomah inspection. I feel compelled to address these issues because the letter was released to the media prior to you contacting me or providing me the opportunity to discuss the matter directly with you.

In the third paragraph of the letter you state that we "did not publicly release the eleven-page administrative closure at the time of the completion and delayed reporting its findings to Congress." As you are aware from various media reports, in June 2014, Senator Tammy Baldwin contacted our office after she received allegations relating to prescription practices at Tomah. She was advised that we had completed work on similar allegations and subsequently requested a briefing. On July 22, 2014, Dr. David Daigh, the Assistant Inspector General for

Healthcare Inspections and Dr. Alan Mallinger, a Senior Physician on staff in the Office of Healthcare Inspections, provided Senator Baldwin's staff with a briefing. Dr. Mallinger is Board Certified in Psychiatry. On August 11, 2014, Senator Baldwin requested a copy of the administrative closure under the Freedom of Information Act, which was provided on August 29, 2014. We received no other requests or allegations relating to Tomah until recently.

It has come to my attention that you, Senator Baldwin, and Congressman Ron Kind received a similar complaint in September 2014. We have reviewed our files and found no record of any referrals or requests to review those complaints. Had we known about these complaints, we would have provided the same information, including a briefing that we provided the staff of Senator Baldwin during the summer. If the information provided in the new complaints warranted further review, we would have reopened the inspection. It is also worth noting that between 2011, when we first received allegations regarding prescription practices in Tomah and the summer of 2014, when we were contacted by Senator Baldwin, we did not receive any additional complaints or allegations regarding this issue.

Although your letter claims that this office is not being transparent, I refer you to the multiple reports we have issued publicly regarding use of opioids as treatments in the VA. These reports can be found on our website. Of particular interest is the report issued on May 14, 2014, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy,* Report No. 14-00895-163. This report presents the results of a study that we conducted at the request of the Senate Committee on Veterans Affairs. We received no requests for a briefing or for other information relating to this or any of the other reports addressing this issue.

In mid-January 2015, we provided briefings to Congressman Kind and the House Veterans Affairs Subcommittee on Health. In response to a request from you, on February 4, 2015, we provided a briefing to Committee staffers. At the conclusion of the briefing, Mr. David Brewer, a Committee staffer, requested the entire "investigative file." About a week later, Mr. Brewer sent an email reiterating his request for the file. Although the Executive Branch does not treat a verbal request or an email from staff as a request from a committee unless the committee chairman has authorized staff to make requests on behalf of the committee, the OIG's Information Release Office obtained relevant files for the inspection and began a review to identify any records that could be released. Due to the nature of the types of documents contained in the file, it was determined that we would not be able to produce a large portion of the file because the records were protected from disclosure by various statutes and/or are privileged. To further discuss the matter and determine the specific oversight purpose for the request, we asked to have a meeting with your staff.

Neither Mr. Brewer's verbal request for the OIG files nor his subsequent email identified a specific oversight purpose to justify the request for the entire file nor did the requests identify what portion of the records would be responsive to a specific oversight purpose. He merely

requested them verbally on February 4, 2015, at the conclusion of the briefing with no explanation as to why they were being requested or any indication that they were being requested by you or any other Member for oversight purposes. In a February 11, 2015, email, Mr. Brewer stated "As you know, HSGAC is the chief investigative committee of the Senate and is authorized by the Senate standing rules to examine 'the efficiency, economy, and effectiveness of all agencies and departments of the Government'. The Chairman has directed us to examine the circumstances surrounding the tragedies at the Tomah VAMC, which includes the review conducted by the VA Office of Inspector General." It is not clear what "tragedies" Mr. Brewer was referring to because the administrative closure did not address any "tragedies." Therefore, the files would not be relevant for that purpose. In contrast, when we recently became aware of specific incidents that could be interpreted as "tragedies," alleged to be related to poor quality care, we opened an investigation and an inspection to address the complaints. These activities are ongoing.

In the last paragraph on page 2 of your letter, you state that the IG Act established inspector generals to assist Congress in its oversight duties by keeping "Congress fully and currently informed by means of [semi-annual reports] and *otherwise*," of fraud and other serious problems, abuses, and deficiencies . . . ." This statement, as presented, is not in the IG Act. The purpose of the IG Act is set forth in Section 2 of the Act. Section 2 (3) states that it was "to provide a means for keeping the head of the establishment and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and the necessity for any progress of corrective action." Section 4 (5) of the IG Act states that it is the duty and responsibility of the IG to "Keep the head of such establishment and the Congress fully and currently informed, by means of report required by section 5 and otherwise, concerning fraud and other serious problems, abuses, and deficiencies relating to the administration of programs and operations administered or financed by such establishment, to recommend corrective action concerning such problems, abuses, and deficiencies, and to report on the progress made in implementing such corrective action." The inspection did not identify any fraud and other serious problems, abuses, or deficiencies relating to VA programs and operations. Accordingly, it was not inappropriate to administratively close the case.

During the meeting with your staff on February 18, 2015, the Counselor to the Inspector General and the Chief Information Release Officer attempted to obtain further clarification of the specific oversight purpose for the request. None was forthcoming. The Committee staff, Mr. Brewer, Mr. Kyle Brosnan, and Mr. Brian Downey, merely cited their authority to investigate and that gave the Committee the power to obtain any records that they wanted. A memorandum issued on June 19, 1989, by the Department of Justice, Office of Legal Counsel, summarized the principles and practices governing congressional requests for confidential executive branch information. 13 Op. O.L.C. 153 (1989). The memorandum addressed "the duty of Congress to justify its requests." *Id.*, 159. As noted in the memorandum, "the process of accommodation requires that each branch explain to the other why it believes its needs are legitimate." *Id.* We

are willing to accommodate this request to the extent possible if the Committee can justify the request.

You state in your letter that the Counselor to the Inspector General was not cooperative because she questioned the Committee's authority and the Committee's purpose. As the Counselor explained in detail to your staff, the file contains records protected from disclosure by various statutes that include criminal penalties for improper disclosure and that the files contained information that implicates Executive Branch confidentiality interests. Ms. Regan explained that the OIG was not going to violate these laws by providing records in response to the request we received. She explained that the file included patient medical records and medical quality assurance records, and that we did not believe there was any authority or need for these records to be released. Statute dictates that veterans have both a right and expectation that personal medical information, which could include diagnosis and treatment of drug or alcohol abuse, HIV, or sickle cell anemia, will not be disclosed outside VA without their consent. Accordingly, Ms. Regan has an absolute right and obligation to ask questions and obtain clarification from the Committee. In fact, this is part of the "accommodation process."

The statements in your letter that the Counselor refused to discuss the types of documents in the record is incorrect. The Counselor explained in detail the types of records in the files and noted that many of the records were protected by confidentiality statutes such as the Privacy Act, and VA statutes protecting certain VA records. In fact, she cited the statutes, 38 U.S.C. Sections 5701, 5705, and 7332, and provided an overview of the information in the records that was protected by each section. She explained that in addition to the Privacy Act, medical and benefits records were protected from disclosure under Section 5701. She also explained that portions of those records pertaining to the diagnosis and treatment of drug or alcohol abuse, HIV, or sickle cell anemia were further protected from disclosure by Section 7332, In addition, she explained that Section 5705 protected medical quality assurance records. In response to a statement by the Committee staff that the Privacy Act does not apply to the Congress, Ms. Regan noted that it does not apply when they receive the records but it does apply to agencies when releasing Privacy Act protected records. The provision that permits an agency to release records to a Congressional committee or subcommittee does not authorize the release of any and all documents, just those relevant to the oversight purpose.

In addition to discussing our general concerns regarding the release of records protected under Sections 5701, 5705, and 7332, Ms. Regan explained that based on our review of the statutes, they do not give the OIG authority to release the covered records in response to a Congressional request or otherwise. The authority to make this decision rests solely with the Secretary for VA. Ms. Regan suggested that we provide the Committee staff with information regarding the types and nature of documents in the file to enable them to obtain the records directly from VA. When this suggestion was rejected outright, she suggested that we ask VA if the records could be released, but that request was also rejected.

In response to a specific request for all records relating to interviews conducted, particularly with current or former employees, Ms. Regan noted that the IG Act itself [Section 7 (b) and 8M (b)(2)(B)] prohibits the disclosure of the identity of individuals who submit complaints or provided information to the IG. Ms. Regan also noted that some records may raise other Executive Branch confidentiality interests.

During the meeting Ms. Regan advised the Committee staff that the file was voluminous and that it would take some time to review the thousands of pages of documents in order to respond to the request. We are continuing our review of the file and are providing those documents that can be released, some with minimal redactions. We will continue to review the files to determine whether there are additional documents that can be released without violating any of the laws discussed above.

In summary, the Counselor not only discussed our concerns about releasing the files in response to the request but offered alternatives which were refused. We are not "stonewalling" the Committee, we are simply adhering to the established accommodation process and seeking to provide records responsive to the Committee's legitimate oversight needs while complying with applicable statutory restrictions.

Sincerely,

Richard J. Griffin
Deputy Inspector General

Enclosure

Copy to: The Honorable Tom Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs

The Honorable Robert A. McDonald
Secretary, Department of Veterans Affairs

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

April 20, 2015

The Honorable Richard J. Griffin
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Deputy Inspector General Griffin:

I write to reiterate again my outstanding request for the production of the Department of Veterans Affairs Office of Inspector General's (VA OIG) case file gathered in the course of its health care inspection of the Tomah VA Medical Center (Tomah VAMC), as well as copies of the 140 previously-unreleased VA OIG healthcare inspections. As noted several times, the Committee seeks to work collaboratively with the VA OIG to arrange for the production of the case file while protecting sensitive patient information.

The Committee is investigating allegations of veteran deaths at the Tomah VAMC, retaliation against whistleblowers, and a culture of fear among the employees at the facility that date back almost a decade. In the course of this work, the Committee has become aware that the VA OIG conducted a multi-year inspection of the facility, examining similar issues and many of the same individuals.[1] This inspection was administratively closed without publication and apparently without your knowledge or approval. Given these circumstances, robust congressional oversight is needed to bring transparency and accountability to the Tomah VAMC, the VA, and the VA OIG.

Over the past two months, the Committee has made several attempts to accommodate the VA OIG's stated concerns about producing the contents of the case file. Since then, the VA OIG has not made a meaningful effort to fully comply with the Committee's request and has instead continued to assert general barriers to compliance. As detailed in my letter to you dated March 11, 2015, the VA OIG has not articulated any constitutional or statutory basis that serves as an absolute barrier to compliance with my request.[2] To date, the VA OIG has asserted no privilege on this material and has declined to produce any of the case file other than a limited, self-selected subset of "background" information.

For these reasons, I reiterate my request for the production of the case file pertaining to the VA OIG's health care inspection of the Tomah VAMC and the 140 previously-unreleased

[1] Meeting between Comm. staff & Catherine Gromek, John Daigh, & Alan Mallinger (Feb. 4, 2015).
[2] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Gov't Affairs to Richard J. Griffin, VA Office of Inspector General (Mar. 11, 2015).

health care inspections your office has completed since 2006. The Committee will accept production of the case file with limited, appropriate redactions for sensitive veterans' health information. If you do not fully comply with this request by 5:00 p.m. on April 23, 2015, the Committee will have no choice but to consider the use of compulsory process to obtain the case file.

The Committee has made multiple attempts to accommodate the VA OIG's specific concerns and the VA OIG has declined to engage with specificity

On February 4, 2015, Committee investigators met with Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections; Dr. Alan Mallinger, a Senior Physician in the Office of Healthcare Inspections; and Catherine Gromek, the VA OIG's Congressional Relations Officer, to discuss the VA OIG's Tomah healthcare inspection.[3] During this meeting, Committee staff learned of – and requested – the VA OIG's case file pertaining to the Tomah VAMC. After Ms. Gromek raised the possibility of general concerns with producing the case file, Committee staff stated that the Committee would work with the VA OIG to accommodate any concerns about producing the documents.[4]

On February 11, 2015, Committee staff wrote to Ms. Gromek inquiring about the case file.[5] In this correspondence, Committee staff again reiterated the Committee's willingness to work with the VA OIG to resolve concerns about particular documents.

On February 18, 2015, Committee staff met with VA OIG staff, including Maureen Regan, the Counselor to the Inspector General – at the VA OIG's request – for what the Committee believed would be a collaborative effort to "work with [the VA OIG] to facilitate the production" of the case file.[6] During this meeting, Committee staff again reiterated the Committee's willingness to accommodate the VA OIG's particularized concerns about individual documents in the case file. Ms. Regan declined to discuss any documents with particularity and refused to share a list of "categories" of the documents in the case file, of which Committee staff requested a copy to better inform the discussion.

Following this meeting, Committee staff emailed Ms. Gromek to reiterate the Committee's desire to work collaboratively with the VA OIG in addressing its particularized concerns about specific documents.[7] In this email, Committee staff requested the "categories" list to inform further accommodation with the VA OIG about its particularized concerns about documents in the case file.

On February 19, 2015, Ms. Gromek replied to Committee staff: "[W]e are looking through the documents in the background category and should be able to provide you with some

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[3] Meeting between Comm. staff and Dr. John Daigh, Dr. Alan Mallinger, and Catherine Gromek (Feb. 4, 2015).
[4] *Id.*
[5] E-mail from Comm. staff to Catherine Gromek (Feb. 11, 2015).
[6] Meeting between Comm. staff and Catherine Gromek, Maureen T. Regan and Darryl Joe (Feb. 18, 2015).
[7] E-mail from Comm. staff to Catherine Gromek (Feb. 18, 2015).

documents on Monday [February 23rd].[8] Ms. Gromek offered no further information in response to the Committee staff's request for clarification, and the Committee received no documents from the VA OIG on February 23, 2015.

On February 25, 2015, I wrote to you to request your cooperation with the Committee's investigation and to ask that you produce the Tomah VAMC case file.[9] On February 27, 2015, you replied in a letter with your general concerns about producing the Tomah VAMC case file.[10] Your letter cited the Inspector General Act, the Privacy Act, and veterans-specific healthcare statutes as general barriers to producing the case file. However, your letter did not identify with particularity any specific concerns about specific documents in the case file. The same day, the VA OIG provided a limited, self-selected subset of so-called "background" material from the case file.

On March 2, 2015, I met with you – at your request – to discuss the Committee's request for the production of the Tomah VAMC case file.[11] Again, you raised generalized concerns about producing the case file, without specifying any particularized concerns about specific documents in the case file.

On March 11, 2015, I wrote to you to address your stated concerns about producing the Tomah VAMC case file and to reiterate my request for the entire case file.[12] This letter detailed the Committee's efforts to accommodate your concerns about producing the case file and explained why your generalized concerns do not present an absolute barrier to compliance with my request. Specifically, I explained that the Inspector General Act and the Privacy Act, as well as the statutes specific to veterans healthcare, 38 U.S.C. §§ 5701 and 5075, contain express exemptions for disclosing information to Congress. I also reiterated the Committee's willingness to work with the VA OIG to alleviate its concerns through limited redactions and *in camera* reviews. In a final attempt toward accommodation, I offered to accept a "detailed list of the contents of the case file to inform additional staff-level discussions about the VA OIG's particularized concerns for each document and options to alleviate those concerns."[13] I requested that you transmit the document to the Committee by March 16 and schedule a staff-level meeting on the issue by March 20.[14]

On March 16, 2015, the Committee received a redacted list of the "categories" of information contained in the VA OIG's Tomah case file.[15] Upon receipt, Committee staff

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[8] E-mail from Catherine Gromek to Comm. staff (Feb. 19, 2015).
[9] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Gov't Affairs to Richard J. Griffin, VA Office of Inspector Gen. (Feb. 25, 2015).
[10] Letter from Richard J. Griffin, VA Office of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec. & Gov't Affairs (Feb 27, 2015).
[11] Meeting between Richard J. Griffin and Ron Johnson (Mar, 2, 2015).
[12] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Gov't Affairs to Richard J. Griffin, VA Office of Inspector Gen. (Mar. 11, 2015).
[13] *Id.*
[14] *Id.*
[15] E-mail from Catherine Gromek to Comm. staff (Mar. 16, 2015).

inquired about the bases of the redactions.[16] Ms. Gromek replied that her "understanding is they are names of the people that we interviewed."[17] After Committee staff asked for the reason supporting the redactions,[18] Ms. Gromek replied, "I believe the Privacy Act as outlined in the [VA OIG's] February 27 letter."[19] Committee staff notified Ms. Gromek that the Privacy Act contains an exemption for disclosing information to Congress and asked for an unredacted list of the contents of the Tomah case file.[20] Ms. Gromek did not respond.

On March 24, 2015, Committee staff conducted a phone call with staff of the VA OIG for the purpose of discussing "the VA OIG's particularized concerns for each document [in the Tomah case file] and options to alleviate those concerns."[21] During this call, Committee staff again reiterated the Committee's willingness to accept limited redactions and *in camera* reviews of some material to alleviate the VA OIG's specific concerns about particular documents. Committee staff attempted to work item by item through the "categories" list – provided by the VA OIG precisely for this purpose – to understand the VA OIG's specific concerns about particular documents and discuss options for further accommodation.

The VA OIG staff, however, declined to discuss any particularized concerns about specific documents, instead repeating the same general barriers outlined in your letter of February 27, 2015. The VA OIG staff indicated that they had not yet reviewed the entire contents of the case file, although the meeting was called precisely to discuss the contents of the case file and despite having several weeks to do so. The VA OIG staff also argued, incorrectly, that the Committee must particularize its need for each document in the case file – a difficulty given the VA OIG's refusal to provide a detailed list of the contents of the case file and the presence of redactions on the "categories" document that was provided.

Since the phone call of March 24, 2015, the Committee has received no further indication from the VA OIG about whether it will begin to comply with my request for the Tomah VAMC case file. Despite two months of trying to understand the VA OIG's particular concerns about specific documents in the case file and several attempts at accommodation, the Committee has received just a limited, self-selected subset of "background" information from the case file. The VA OIG continues to withhold an overwhelming portion of the material contained in the case file.

There is no absolute barrier to the production of the Tomah VAMC case file

The federal statutes you cite as barriers to your compliance with my request for the Tomah VAMC case file – the Privacy Act,[22] the Inspector General Act,[23] 38 U.S.C. § 5701, and

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[16] E-mail from Comm. staff to Catherine Gromek (Mar. 16, 2015).
[17] E-mail from Catherine Gromek to Comm. staff (Mar. 16, 2015).
[18] E-mail from Comm. staff to Catherine Gromek (Mar. 16, 2015).
[19] E-mail from Catherine Gromek to Comm. staff (Mar. 16, 2015).
[20] E-mail from Comm. staff to Catherine Gromek (Mar. 16, 2015).
[21] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Gov't Affairs to Richard J. Griffin, VA Office of Inspector Gen. (Mar. 11, 2015).
[22] 5 U.S.C. § 552a.
[23] 5 U.S.C § 1 et. seq.

38 U.S.C. § 5705 – each contain an express exemption allowing for the disclosure of information to Congress. In addition, as explained in my letter of March 11, 2015, the IG Act makes clear that inspectors general are considered to be separate entities from the agencies they oversee.[24] I do not believe there to be any reason why the VA OIG must seek the approval of the VA to disclose to the Committee material that is in the custody and control of the VA OIG.

The IG Act specifically states that nothing in the Act "shall be construed to authorize or permit the withholding of information from Congress, or from any committee or subcommittee thereof."[25] Other inspectors general have provided information to Congress, including material with Executive Branch confidentiality interests. Most recently, at my request, the Inspector General of the Department of Homeland Security (DHS OIG) released hundreds of source documents supporting its recent report into the EB-5 visa program.[26] The DHS OIG released this material, in its own words, "to be transparent to both the public and Congress."[27]

As I have repeatedly explained, the Committee has requested the VA OIG case file as a part of its investigation into the Tomah VAMC. The VA OIG must comply with the request or explain with particularity the reasons that it cannot produce the documents. To date, the VA OIG has not offered any particularized concerns about specific documents that the Committee has not been unwilling to accommodate. The VA OIG has articulated no claims of privilege as bases for withholding the documents. In sum, therefore, my request for the production of the Tomah VAMC case file remains outstanding despite numerous attempts by the Committee to reach accommodation with the VA OIG.

Conclusion

I am deeply troubled by the VA OIG's noncooperation with the Committee's oversight efforts of the VA and the VA OIG. The Committee's inability to obtain the Tomah VAMC case file not only hinders the Committee's investigation of the Tomah VAMC, but also prevents the Committee's ability to craft potential legislative solutions to enhance the transparency and accountability of Inspectors General.

In addition, during this investigation, the Committee has learned of the existence of 140 other healthcare inspections – similar in nature to the nonpublic Tomah VAMC inspection – that the VA OIG closed administratively. I have written to you to request that you produce, without redactions, these 140 previously-unreleased health care inspections your office has completed since 2006.[28] Although Committee staff has attempted to work with the VA OIG to facilitate production of the inspections, the Committee's accommodation efforts have not been reciprocated and my request for the 140 inspections remains outstanding.

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[24] 5 app. U.S.C. §§ 2, 6.
[25] 5 U.S.C. § 5(e)(3).
[26] Letter from Ron Johnson, S. Comm. Homeland Sec. & Gov't Affairs to John Roth, Dep't Homeland Sec. Office of Inspector Gen. (Mar. 27, 2015).
[27] Dep't of Homeland Sec. Office of Inspector Gen., IG Releases Documents Underlying Investigation of Employee Complaints Regarding Management of USCIS' EB-5 Program (Apr. 9, 2015).
[28] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Gov't Affairs to Richard J. Griffin, VA Office of Inspector General (Mar. 17, 2015).

I request that you produce the VA OIG's Tomah VAMC case file and unredacted copies of the 140 previously-unreleased health care inspections the VA OIG has completed since 2006 immediately, but no later than 5:00 p.m. on April 23, 2015. If you have not fully complied with this request by that time, the Committee may consider the use of compulsory process. Thank you for your attention to this manner.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Minority Member

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

April 24, 2015

The Honorable Ron Johnson
United States Senate
Chairman, Committee on Homeland Security and
Governmental Affairs
Washington, DC 20510-6250

Dear Chairman Johnson:

This is in response to your April 20, 2015, letter regarding your request for the production of the Department of Veterans Affairs Office of Inspector General's (VA OIG) case file gathered in the course of its health care inspection of the Tomah VA Medical Center as well as copies of the 140 administrative closures by the VA OIG's Office of Healthcare Inspections (OHI) that were reported to VA, the Congress, and the public in our Semi-Annual Reports to Congress.

With respect to the administrative closures, during the March 24, 2015, conference call, my legal staff explained to your staff that we had multiple requests for the administrative closures, including requests under the Freedom of Information Act (FOIA), and were in the process of reviewing all of the documents for release. Prior to the March 24, 2015, call, 23 of the 140 closures were uploaded to our website and it us my understanding that your staff had accessed and reviewed those reports prior to the call. We have since completed the reviews and are in the process of uploading them to our website. The process has been ongoing since Tuesday April 21, 2015. I expect the process to be completed on or before Monday April 27, 2015. My staff explained during the telephone call that the processes for reviewing documents for public disclosure and posting them on our website are both time consuming and resource intensive. In addition, the administrative closures are not the only records we are reviewing for release in response to requests from other Congressional Committees and individual Members, under FOIA, for discovery in various cases, from the Department of Justice, in response to subpoenas, and in response to requests from VA. As you are aware, there are specific statutory deadlines for responding to many of these requests.

With regard to the Tomah inspection, your statement the "Committee has made multiple attempts to accommodate the VA OIG's specific concerns and the VA OIG has declined to engage with specificity" is not accurate. As detailed in my February 27, 2015, letter, my legal staff has clearly identified its position regarding the release of the entire file to you, purportedly for Committee purposes.

During the meeting with your staff on February 18, 2015, the Counselor to the Inspector General and the VA OIG's Chief, Information Release Officer attempted to obtain clarification regarding the specific oversight purpose of the request and none was forthcoming at that meeting, in your February 25, 2015, letter, or during our March 2, 2015, meeting. In my February 27, 2015, response to your letter, I cited a statement in an email sent to us by Mr. David Brewer in which he stated: "The Chairman has directed us to examine the circumstances surrounding the tragedies at the Tomah VAMC, which includes the review conducted by the VA Office of Inspector General." As I stated in my letter, it is not clear what "tragedies" Mr. Brewer was referring to because the administrative closure did not address any "tragedies" and I further stated that the records requested would not be relevant for that oversight purpose. I also noted that, in contrast, when we recently became aware of specific incidents that could be interpreted as "tragedies," alleged to be related to poor quality care, we opened an investigation and an inspection to address those complaints. These activities are still on-going and those records are not part of the file requested.

During the March 26, 2015, hearing held by the Senate Veterans Affairs Committee, *Opioid Prescription Policy, Practice, and Procedures*, Dr. David Daigh, the Assistant Inspector General for Healthcare Inspections, was asked when the VA OIG was first aware of the problems at Tomah. Dr. Daigh responded that we received a complaint in May 2011 regarding improper care that was sent to the Veterans Integrated Systems Network (VISN) for a response and that the VISN responded that there were no problems. Dr. Daigh further testified that he received a second Hotline several months later which was the basis for the inspection. You stated that you were conducting an investigation to inquire how far back this went and who knew so that these "tragedies" don't happen again. You further stated at the hearing that you wanted to know who knew what and when to hold people accountable. Based on your statement at the hearing in which you defined the scope of your investigation, we began reviewing the inspection files and other VA OIG records to focus on identifying any documents that may be responsive. Because we did not substantiate the Hotline allegations, it was not necessary for the inspectors to determine who knew what and when to hold people accountable.

Based on an in-depth review of the VA OIG files, we determined that the first complaint we received regarding the issues at Tomah was March 11, 2011. As Dr. Daigh testified during the March 26, 2015, hearing, this complaint was referred to the VISN for a response. I have attached a copy of our referral and the VISNs response, with the exception of quality assurance records protected under 38 U.S.C. Section 5705. As we have explained, we do not believe we have the statutory authority to release these records. We also redacted the name of the veteran but left the last 4-digits of the Social Security number, which is needed to cross reference the referral with the response. We did not conduct any further review of the allegations addressed by the VISN. We found no records in our files showing that the VISN, or for that matter anyone else in VA, was aware of these complaints prior to our referral.

In your April 20, 2015, letter you state, that the "Committee is investigating allegations of veterans deaths at the Tomah VAMC, retaliation against whistleblowers, and a culture of fear among employees at the facility that date back almost a decade."

Our healthcare inspection did not address allegations of deaths at the Tomah VAMC; therefore, the file does not include any records responsive to this aspect of your investigation. If there is a specific death you believe may have been brought to our attention during the review, please let us know and we will recheck our files. Although the May 2011 Hotline complaint did include allegations relating to the care provided specific patients, these cases were reviewed by the VISN and we did not include them as part of our inspection.

Our inspection focused primarily on an anonymous complaint that we received in August 2011. We have attached a copy of the document that was provided to you prior to the hearing at the Tomah facility on March 30, 2015. In addition to complaints relating to prescribing practices, the allegations included:

1. If anyone disagrees with the Tomah VA Chief of Staff (COS), he finds a way to get rid of them.
2. A police officer who patrols the VA (not a VA employee) tried to arrest a veteran who was selling narcotic prescriptions on VA premises. The veteran called the COS and the police officer was told he would be fired if he arrested the veteran.
3. The complaint was prompted by an incident in which a prescription for narcotics was refilled early because the veteran was leaving that night. However, on Sunday, the veteran checked himself into the VA hospital confused and belligerent. The veteran had not left town but spent the weekend on a cocaine and marijuana binge. The vet stayed in the hospital for over a month detoxing and getting his life together. After discharge, the veteran complained of pain and the COS prescribed oxycodone and a few days later the veteran was back in the hospital after another cocaine binge.
4. There had been numerous complaints from the Tomah police department about drug trafficking from the VA.
5. There were complaints from the Milwaukee police.
6. Veterans have said that the VA turned them into dope addicts.

We have no record or other information to show that anyone in VA received the complaint. The letter we received stated that it was sent to "all of Wisconsin's senators and representatives" and Representative Ron Kind did forward a copy of the letter to the VA OIG Hotline on September 29, 2011. We do not know whether the letter was actually sent to or received by any other Member.

The letter provided no specific information such as dates, times, places, the identity of individuals who have personal knowledge of the allegations, including the identity of the

veterans referenced in the letter, nor does it indicate who knew what and when. The fact that complainant was anonymous precluded us from following-up with the complainant to obtain more specific information. One of the problems we encountered in conducting this inspection was the lack of firsthand knowledge regarding any of the allegations. Gossip, rumor, and innuendo do not constitute credible evidence on which to base a finding or conclusion.

We were unable to verify or substantiate the allegations in the August 2011 letter. More specifically:

- We were unable to identify any evidence to substantiate the allegation that the Tomah COS allegedly interfered in the arrest of a veteran for selling drugs on VA property. More specifically, we were unable to verify that the incident occurred despite efforts to identify the veteran and/or the police officer. Accordingly, we do not have any records to substantiate or refute the allegation.
- We were also unable to substantiate the allegation relating to the veteran who allegedly received an early refill on his prescription then binged on cocaine and marijuana over the week resulting in an extensive hospitalization for detoxification. As previously noted the complainant was anonymous and did not provide specific information such as the patient's name, the date the incident allegedly occurred, etc., which made it difficult to follow-up on. Accordingly, we did not report on this allegation and we have no record to produce.
- We also were unable to substantiate the allegations that there had been numerous complaints from the Tomah police department about drug trafficking from the VA or that there were complaints from the Milwaukee police. VA OIG healthcare inspectors and criminal investigators did reach out to local law enforcement in an attempt to obtain information to verify the allegations relating to their concerns about drug trafficking or other related issues at the Tomah VA. Attached are the reports of interview. The Tomah Police department who related that there had been a history of drug problems in the past at the VA and noted that around 2006-2008 there was a large cocaine conspiracy investigation which led to the arrest of several VA employees. The Tomah police department reported that they had no currently active drug investigations at the Tomah VA. Although they had allegations and suspicions, nothing had been investigated or substantiated. When asked about the allegation that the COS interfered with an attempted arrest of a veteran. the Tomah police could not verify the story and the Chief told us that it was unlikely. Similarly, we contacted the Milwaukee Police Department and were told that they did not have any current involvement with or concerns about Tomah VA. A copy of our report of interview with the Milwaukee Police Department is attached. Based on the information provided, we did not substantiate the allegations relating to complaints from these law enforcement agencies regarding the Tomah VAMC or the incident in which the COS allegedly interfered with an arrest. We also reached out to the

Drug Enforcement Agency who was not aware of any arrests for drug distribution or other violations relating to the Tomah VA and the prescribing practices of the Tomah COS. They had recently received an allegation that the Tomah COS was providing opiates to a specific patient. A copy of the interview with DEA is attached. The Office of Healthcare Inspections did not address this issue during its inspection. However, the specific allegation relating to the Tomah COS was investigated and not substantiated. The allegations received by the local law enforcement entities and the DEA did not result in any arrests.

- We did not identify any veterans who claimed that the VA had turned them into dope addicts. Accordingly, we have no records to produce.

We did not receive any allegations that employees were retaliated against for whistleblowing. As such, the inspection file does not contain any records that would be responsive to this issue. Information about whistleblower retaliation would be maintained by VA. Employees who believe that were retaliated for whistleblowing can seek relief directly through the Merit Systems Protection Board (MSPB) if the action against them is directly appealable to the MSPB or if the Office of Special Counsel (OSC) declines to take action on their behalf. Because whistleblower retaliation was not addressed during the inspection, we did not request any records from VA or OSC, nor did we research decisions by the Board.

With regard to the third stated focus of your investigation, the culture of fear among employees at the facility that date back almost a decade, our inspection did not focus directly on this issue and no one provided us with any specific information during our review from which we could conclude that such an atmosphere existed. As noted previously, hearsay, gossip, and rumor are not reliable evidence. The best source of information regarding this issue would be complaints or grievances filed with the local unions, complaints of discrimination, including hostile work environment, filed with VA's Office of Resolution Management, and complaints filed with the OSC. We do not have the records that would provide you with the information you need to this issue. You should contact VA or OSC directly.

In response to a question you posed at the March 26, 2015, hearing, Dr. Daigh testified that we were not going to launch an investigation into who in VA knew what and when. We did, however, review our Hotline files and our files relating to Congressional inquiries and found that there were no complaints relating to prescription practices, reprisal for whistleblowing, veterans deaths, or intimidation and an environment of fear at the Tomah VA prior to the complaint received in May 2011.

We did review an allegation brought to our attention during the inspection that the Tomah COS was involved in the termination of Dr. Noelle Johnson during her probationary period but were unable to substantiate that he was involved in the decision to remove her. We do not have

records relating to her employment in our files. We also investigated a concern that acts or omissions by the Tomah COS caused or contributed to the suicide of a psychologist at the medical center but found no evidence to support the concern.

During our inspection, another Office of Healthcare Inspections team conducted a routine, cyclical Combined Assessment Program review of the facility. As part of these reviews, we conducted an Employee Assessment Review (EAR) survey in which we ask employees to anonymously provide responses to specific questions in an effort to get a better understanding of the facility and concerns that they may have. The EAR survey completed in May 2012 identified concerns regarding the prescribing practices which we incorporated into our inspection plan. We did not share these particular concerns with VA during the inspection. We did not receive similar complaints on the most recent EAR survey for the Tomah facility, which was completed in September 2014. I have attached copies of documents relating to the 2012 and 2014 EAR surveys.

In summary, other than providing records relating to the March 2011 Hotline complaint that we referred to the VISN for a response, we do not have any records to show who knew what and when regarding the prescribing issues. With respect to veterans' deaths, we did not review this issue and do not have any records to produce. We are, however, providing documents relating to our interviews with local law enforcement and the DEA that do not support the allegations in the August 2011 complaint letter. Because the inspection did not address allegations of reprisal for whistleblowing, we have no records to produce relating to this issue. Similarly, we have no records to produce showing a culture of fear at the facility for a decade. As noted above, VA would have records relating to specific complaints brought to their attention through complaints, grievances, and unfair labor practices files with the local unions, EEO complaints alleging discrimination and/or hostile work environment, complaints filed with OSC, and appeals to the MSPB.

The current work by the VA OIG Office of Healthcare Inspections being conducted in response to allegations relating to the deaths of Jason Simcakoski and Thomas Baer is progressing and we expect to be able to report on the results within the next 60 days.

If there is an issue regarding a specific veteran or event that you have reason to believe we reviewed and would be responsive to your investigation, please let us know and we will check our records to determine whether we have any responsive documents.

My staff is willing to discuss the information provided in the documents produced with this letter should you have any questions or need clarification. Within the legal limits outlined in my February 27, 2015, letter, your staff is welcome to come to our office to review *in camera* any additional records responsive to your investigation, if desired.

Sincerely,

Richard J. Griffin
Deputy Inspector General

Enclosures

Copy to: The Honorable Tom Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs

The Honorable Robert A. McDonald
Secretary, Department of Veterans Affairs